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## ORIGINAL DEPARTMENT.

### COMMUNICATIONS.

#### TYPHO-MALARIAL FEVER: IS THERE SUCH A DISEASE?\*

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Is there such a specific disease as typho-malarial fever—a hybrid disease, produced by the joint action of two specific poisons, each one of which, acting alone, would produce a different and distinct disease?

I unhesitatingly answer in the negative. In medicine we are too prone to use terms to hide our ignorance, or to attempt to explain some phenomena of diseases that are unusual. Typhoid pneumonia, typhoid bronchitis, typhoid everything, are in many cases subterfuges and scape-goats, excuses for delays in curing cases or relieving patients that we are treating. In the same way, a case of remittent fever that is disposed to be obstinate, and does not respond to usual remedies, is designated typho-malarial. At the very outset of these remarks I wish not to be misunderstood. I do not deny the to-some-extent co-existence of malarial poison as a complication of typhoid fever (though this is denied by some of our best medical writers), nor do I deny the effect of the malarial poison, whether that poison be of an animal or vegetable parasitic nature or not, in producing departures from a *typical* case of typhoid fever. I would not deny this effect upon typhoid fever any more than I would the same as producing departures from *typical* cases of pneumonia, bronchitis, scarlatina, and most other diseases that occur in a

section where malaria abounds. How few cases of pneumonia in our section of this State present a typical temperature chart, and how many of them show great variations between the morning and the evening ranges! How few cases of typhoid fever show a daily range of only  $1\frac{1}{2}$  to  $2^{\circ}$ . I trust then that my position is plainly stated: that malaria may complicate typhoid fever, as it may any other disease, but that the result is not a hybrid disease.

We all know that in different years, and frequently that at different seasons of the same year, the same disease will present different types; at one season being of a sthenic type, at another of an asthenic type. At one time, and with one type of a disease, we will use depressing, sedative remedies; at another, with the other type of disease, we will resort to the remedies of the opposite class. No physician who has been treating cases in which the marked tendency in *all* had been the asthenic type of disease, would bleed a patient with pneumonia or resort to any other depressing remedy. So too in cases of malarial fevers, we may have in them at times a tendency to a pernicious type of disease, and a disposition to continue and become, so to say, typhoid, from the very fact that the tendency to adynamia is not recognized, and the treatment resorted to either pushes the fever on in that direction, or at least does not check the innate tendency thereto.

No physician here present will venture to assert that at all times, and under all circumstances, a given amount of quinine will cure remittent or intermittent fevers. How often has he found the opposite state of facts to be true? Many of our malarial fevers

\* Read before the Medical Society of the State of Tennessee, April 6, 1886.

are easily met by moderate doses of quinine, many by larger doses, and upon some quinine seems to have no effect. These continue, running a course of from three to six weeks, and then either apparently respond to quinine, or recover without, or in spite of it. These are the cases that too often many are disposed to call typho-malarial. In doing this, they base their diagnosis upon the fact that quinine, which is considered a specific against the organisms producing malarial fevers, has failed in this particular case. They forget that in some cases much larger doses are required to combat successfully the poison, and have been using enough to only excite the system and cause the germs to grow more vigorously.

Then, too, it cannot be denied that there are persons from whose systems quinine is eliminated so rapidly that it has no effect, under ordinary circumstances, upon the disease. It must, in treating such cases, be remembered that in three hours after the administration of quinine its presence can be detected in the urine of the patient, and that in proportion as the quantity excreted is large, so must the quantity administered be increased. In some few cases, when administered by the mouth or rectum, quinine purges, and of course does no good. In such cases the hypodermic administration of the remedy might be effective, when it would signally fail in any other way. Many physicians diagnose as typhoid fever any continued fever that refuses to respond to the use of quinine in full doses, without regard to the distinctive abdominal symptoms of that fever, or to any of the foregoing facts.

All present, doubtless, know the origin of the term typho-malarial.

Dr. Daniel Drake, about fifty years ago, recognized the fact that typhoid fever received certain impressions from existing malarial poisons. Observant clinicians have noticed this fact in all parts of the malaria-producing zone, though generally it has been greatly exaggerated. The word, or term, typho-malarial, was coined by Surgeon J. J. Woodward, to express his conception of a composite fever. The war gave rise to many expressions, but to none furnishing a nicer subterfuge to physicians than typho-malarial. The name itself is sufficient in many families to account for the duration of an attack of continued remittent fever. To tell a patient that he has remittent fever is to lead him to expect to recover in a short time, a week or two at most; but call it "typho-malarial," and if he escapes with his life he is thankful. This an age of high-sounding technicalities,

and a physician ought to be excused for attempting to coin a new name for an old disease.

Surgeon Woodward, when treating those cases of fever which occurred amidst the swamps of the Chickahominy, and that, too, among men who, in many instances, had never before been exposed to malarial influences, might reasonably have thought that he had discovered a new fever. Soldiers exposed for the first time to miasmatic or malarial poisons, furnished the best nidus that could have been selected for the growth of the disease germs. Thousands of the army were attacked. Dr. Woodward reports 57,400 cases of typho-malarial fever, with 5,360 deaths, it being a death-rate of a little more than nine per cent. In the same statistics he reports 79,462 cases of pure, uncomplicated typhoid fever, with 30,336 deaths, the death-rate being a little more than 38 per cent. Note the contrast in the two death-rates, the former being not quite one-fourth the latter. Had the first set of cases been what is usually claimed as a combination or joint action of the two poisons, producing a specific disease, known as typho-malarial fever—a fever in which we have a remittent form or type of fever followed by a typhoid fever, modified, and then this by an intermittent or remittent fever, the death-rates certainly ought to have been reversed, unless as Dr. Bemiss holds "the presence of malaria in the blood does not exercise an unhappy influence upon disease due to the specific poison of typhoid fever." A further begging of the question upon this point of death-rate of the two diseases asserts, "It may, on the contrary, be ascertained that it (malaria) modifies the typhoid process, so as to deprive it of some of its most dangerous features." This statement is made in the face of a well-known and generally recognized fact, which he had stated in the same paragraph as follows: "When an acute inflammation is complicated with malaria, its prognosis is more grave." He might have gone one step further with another truth, which we in West Tennessee recognize, "that the prognosis in *any* acute disease is rendered more grave when complicated by malaria." Prof. Flint, in his excellent work on the Practice of Medicine, in referring to the death-rate in the so-called typho-malarial fever, says: "The duration of the febrile career is apt to be longer and the gravity of the disease is greater."

These troops were surrounded by everything favorable to the development of grave types of intermittent and remittent fevers,

which diseases would not respond to the usual doses of quinine and the routine treatment nearly always resorted to in hospital practice. These cases lasted from two to five weeks, and an excuse for so doing must be found, hence the coinage of the term typho-malarial as applied to fevers.

Later on, Dr. Woodward in 1876 retracted his statement made, in which he had claimed this as a specific fever, and at the International Medical Congress held in Philadelphia in that year, offered the following resolution, which was adopted: "Typho-malarial fever is not a specific or distinct type of disease, but the term may be conveniently applied to the compound forms of fever which result from the combined influence of the causes of malarial fevers and of typhoid fever." Whilst the term might be *conveniently* applied, we would have the same right to hybridize some name to apply to bronchitis, which so frequently occurs in the course of typhoid fever. The one is no more a complication than the other.

Dr. Bartholow always opposed Surgeon Woodward's ideas in reference to typho-malarial fever, asserting as follows: "Typho-malarial fever has then no reason to be admitted as a morbid entity into nosological systems—does not in fact exist. All that can be claimed for it is, that when typhoid fever occurs in an individual saturated with malaria, the fever is modified somewhat in its course—has more of the remittent type, and is apt to be more protracted, owing to the occurrence of intermittents during convalescence." He too, then, would clearly hold that the death-rate shown by Dr. Woodward in his cases occurring among the soldiers in the Chickahominy swamps proved conclusively that they were only severe cases of remittent fever.

As late, however, as 1884, Dr. Bartholow, in referring to the so-called typho-malarial fevers, is more pronounced in his views against the existence of any such hybrid disease. He says: "I much doubt the existence of a typhoid fever whose symptoms are modified by a malarial fever. Indeed, there are reasons for believing that in a certain sense an antagonism exists between the two, so far that in the presence of the typhoid poison the malarial ceases to be active. I have always held that the thermal line of typhoid fever might receive an impression from a co-existing malarial complication, might, therefore, become more distinctly remittent, but further experience has weakened this belief. If the morbid anatomy of typhoid fever is not thus affected, why the

symptomatology? Examined anew in the light of a wider experience, I have been conducted to the conclusion that the modification in the thermal line supposed to be due to a malarial complication, has, for the most part, no real existence." (*Medical News*, September 13, 1884.) It is impossible to make a diagnosis of such a disease as typho-malarial fever. It is either typhoid fever or it is malarial. In malarial fevers we have none of the peculiar abdominal symptoms of typhoid fever, and when these abdominal symptoms exist, viz: "meteors, tenderness on pressure, especially in the right iliac region, and gurgling, especially the two former, conjoined with diarrhoea, or a tendency to hypercatharsis, with ochre-colored discharges, typhoid fever is present." There may be a decided diurnal range of temperature, but still it is a case of typhoid fever, and will run a definite course unchecked by quinine, the controller of malarial fevers. It is true that the administration of quinine in typhoid fever will stop the excessive diurnal variations in temperature, but it will do the same in all other diseases, by virtue of its antipyretic effect.

No authority examined by me has made any effort to differentiate the disease by post-mortem examinations. The lesions shown in cases which had been diagnosed as typho-malarial, were either those of *typhoid* fever *alone*, or of *malarial* fever *alone*. There were found either the diseased Peyerian patches, and solitary glands, or the enlarged and softened spleen and liver, together with the characteristic bronzing of the latter organ. A distinct disease ought to present features, either during life or after death, by which it could be positively diagnosed; and one in which this cannot be done, has no claim to a separate entity. Hartshorne, in Reynolds's System of Medicine, referring to the so-called typho-malarial fever, quoting Surgeon Woodward's idea, represents the fever as one due to three distinct poisons, viz., that of malarial fever, the specific typhoid poison, and the poison of scorbutus, and that whatsoever one of these elements or poisons is in excess, it controls the type of the disease, making present either malarial, typhoid, or scorbutic symptoms. As said already, I do not attempt to deny in toto the existence of these complications, or their effect as such upon typhoid fever, when present, but they are simply complications. In reference to the morbid anatomy in these cases, it is said by the writer above referred to, that the most important was the intestinal lesion "*similar* to that of typhoid fever, but not identical."

He adds further, whilst claiming the presence of malaria, "We have the local lesion of the glands of Peyer, and the mucous membrane of the bowels, recalling enteric or typhoid fever," thus admitting exactly what we have claimed, namely, the existence of typhoid fever.

Dr. Bemiss, an advocate and supporter of the typho-malarial idea, is cautious in making a diagnosis of the existence of typho-malarial fever, unless the nervous symptoms are well marked, together with the bowel symptoms, and rose spots. He determines the presence of malaria by the previous history and symptoms early in the attack, chief among which is the decided rise of fever in the onset of the disease, but admits that if the morbid processes of typhoid fever are violent, there may be stages where it is impossible to detect the presence of malaria *per se* in the case. He holds, however, that the *typhoid condition* in malarial fevers can generally be differentiated without trouble. In other words, we cannot have typho-malarial fever without a case of true typhoid fever, and that the malarial complications show themselves early in the disease by irregularities in the daily range of temperature. This is another case of "*petitio principio*," for any one who has practiced in a section abounding in malaria will admit that all diseases are more or less altered in type by its presence. Surgeon Woodward in describing his typho-malarial cases writes as follows: "Of the form in which the malarial element prevailed, the somewhat abrupt commencement, gastric disturbance, icteroid skin and tongue, with remissions tolerably distinct, were predominant features. The lenticular spots of typhoid fever and the sudamina were often wanting." A more striking picture of pure, uncomplicated, severe, not to say pernicious, cases of remittent fever could scarcely be drawn. Evidently the reason for such cases being called typho-malarial was because they did not readily respond to quinine. The abdominal symptoms in those cases of so-called typho-malarial fever were those of malarial fever alone, and this fact ought to have aided much in making a diagnosis in cases otherwise obscure. In most cases constipation existed, though in a few there was diarrhoea, but in all the discharges were dark, tarry, or green, not ochre-colored, as in typhoid fever.

Dr. Bribach, in the *St. Louis Courier* of August, 1885, attempts to diagnose typho-malarial fever from typhoid fever by asserting that in typhoid fever the prodromal symptoms would probably be more prolonged, whilst we know that the prodromic period is

a very uncertain time, varying, according to Prof. Flint, from one to ten days. That the temperature of typhoid fever does not attain its maximum on the first day; but we know that when typhoid fever is ushered in by a well-marked chill, as it sometimes is, it would be reasonable to expect a maximum temperature at the outset. That the abdominal symptoms are wanting in the great majority of typho-malarial cases, but these are the very ones which we contend are remittent fever cases. That in those which are complicated by diarrhoea, gurgling, and tenderness over the caecum, the diagnosis is for the time difficult or impossible. He differentiates the disease from the *remittent fever* by the quinine test alone. He says: "If quinine in full doses *i. e.*, two twenty-grain doses in the first day, and twenty grains in a single dose on the second and third days, produces a state of complete apyrexia on the third and fourth days the disease is not typho-malarial fever." He forgets a fact stated in the first of this article, that some persons are not specifically affected by quinine, and upon them it seems to have no effect; and again, as a test, it would be far surer to use smaller doses (grs. iv.), repeated every two hours, than to attempt to make a diagnosis on a single large one. In his history of typho-malarial fever he says that bronchial catarrh was so frequently present that it could hardly be called a complication. In this same article, the writer holds that typho-malarial fever "is clearly a misnomer; that the disease presents a distinct type of continued malarial fever mostly resembling a variety described by Dr. Maury under the head of 'malarial continued fever.'" From a careful study of his description of the cases treated by him, I am satisfied that the disease was an obstinate remittent fever, with an occasional mild case of typhoid fever, and his acceptance of the term "malarial continued fever," is a virtual concession of everything we have claimed in this article.

The death-rate in Dr. Bribach's cases of so-called typho-malarial fever was only one in twenty—even less than in those of Dr. Woodward; whilst Prof. Flint holds, and common sense teaches, as already stated, that the mortality ought to be greater in typho-malarial than in typhoid fever.

In the paper read by Dr. Evans, of Shelbyville, before the 1885 meeting of this Society, the fever described by him is the one we always have in this section of the State, when typhoid fever in a severe form appears. He uses the following language in his article on typho-malarial fever: "Again, whilst we

rarely see the characteristic pathological symptoms of typhoid fever, the ataxic symptoms are well marked: such as low delirium, subsultus tendinum, diarrhoea, with tympanites, iliac tenderness, and sometimes hemorrhage of the bowels, which adds greatly to the gravity of the disease." This, in my experience, is the typhoid fever of West Tennessee. In patients surrounded by, and under, malarial influences, their systems are more or less saturated with this peculiar poison, and hence we have frequent departures from typical cases of typhoid fever, as described by Louis, but nevertheless the disease is typhoid fever. The intercurrent complications do not change the character of the typical lesions. There are many circumstances that favor this non-conformity to type in typhoid fever, and I assert boldly that almost every physician, who has treated a score of cases of this fever, has met with not more than two cases presenting exactly similar symptoms. And again, I assert that we treat cases of what we are disposed to call "continued fever," presenting not more than one or two symptoms of typhoid fever, and shortly after, or during the convalescence of the first case, a second one occurs in the same family, and then a third, a fourth, and probably others—none of them typical cases of typhoid fever, but when grouped together, a clear and unmistakable diagnosis of typhoid fever is made. These are sometimes the cases diagnosed typho-malarial, but oftener obstinate cases of remittent fever are so called.

In my own practice I have met with cases of remittent fever that have continued from two to four weeks in spite of quinine, and which I would have been glad to have diagnosed as typhoid fever, or better still, as typho-malarial.

I have recorded one case, which occurred August 3d, 1873, as my first experience with obstinate remittent fever. This patient presented the usual symptoms of an ordinary attack of remittent fever, but no effect could be produced upon it by quinine (ergo, a case of typho-malarial fever, as would be claimed by those who support the typho-malarial theory). Quinine was given in large doses, and in small doses, per orem, with no effect, so far as terminating the fever was concerned. After using many remedies for more than two weeks, the case recovered rapidly under ten-drop doses of fl. ex. gelsemium, carried to the extent of producing ptosis and double vision.

In another case, which I treated in August, 1883, the patient presented many of the symptoms of typhoid fever, except hyper-

catharsis, and tympanitis, and would not respond to quinine, per orem or per rectum.

On the fifteenth day of the disease, I began the use of fl. ex. eucalyptus 3 j every four hours, with a decided amelioration of all the symptoms in twenty-four hours, and a complete abatement of the fever on the twenty-first day, and a rapid convalescence. These two cases are examples of that class of cases that practitioners of medicine are too ready to denominate typho-malarial.

No doubt many so-called cases of typho-malarial fever would respond readily, as did those two, to the use of some other antiperiodic. Quinine will not cure all cases of malarial fevers. Nearly all medical writers recognize this fact.

In those obstinate cases, it becomes necessary to produce a decided impression upon the nervous system, and whilst gelsemium may act promptly in one case, and eucalyptus in another, strychnia may be better in a third, arsenic in a fourth, and so on.

Some practitioners show excellent results in those cases of continued remittent fevers from the use of tartar emetic.

Many are disposed to diagnose a case as typho-malarial, when all of the other symptoms of typhoid fever co-exist with constipation, regarding constipation as contradicting the existence of typhoid fever, in face of the evidence of such authorities as Flint, Murchison, Hutchinson, and many others to the contrary. The last case of typhoid fever which I treated showed no tendency to diarrhoea; in fact, the bowels acted from enemata only, used once or twice per week. I might refer to other points of minor importance connected with the subject, but I desist.

#### CIRCUMSCRIBED PERITONEAL DROPSY SIMULATING OVARIAN DROPSY.\*

BY H. P. C. WILSON, M. D.,

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*Mr. President and Gentlemen of the Academy of Medicine:* I desire to call your attention this evening to a case of circumscribed abdominal dropsy, limited by peritoneal adhesions so complete as to accurately simulate ovarian dropsy. It could not be called cystic dropsy, because the fluid was not contained in a distinct sac; but by adhesions from gen-

\* Read before the Academy of Medicine, March 2, 1886.

eral peritonitis, the fluid was restricted to the front and lower part of the abdomen, and not allowed to gravitate throughout its whole extent. Change of the patient's position did not change the position of the fluid, and there was nothing in her history or symptoms to cause us to suspect a former, or recent, peritonitis. She had never been sick a day in her life, and all her organs were acting well.

Mrs. Jas. P., married, at 38. The mother of seven children—twins once, four miscarriages—four times delivered with forceps. Began to menstruate at 14. Noticed a swelling in the abdomen 1st of September, 1885. Could not locate its beginning in either groin or lower abdomen. Has had regular menstruations always, except when pregnant.

She was sent to me by Dr. N. B. Baker, one of the most eminent physicians in Martinsburg, with the statement that she had an ovarian tumor. I confirmed his diagnosis, when she was admitted to the Union Protestant Infirmary, February 12, 1886.

She had a prominent fluctuating tumor of the lower abdomen. Dull on percussion to two inches above the umbilicus, dull in either groin, and presenting the characteristic roundness and prominence of a cystic tumor of the ovary. Percussion was clear in both lumbar regions. Changing the patient's position did not change the lines of dulness anywhere. There was no tenderness over the abdomen to any amount of thumping or pressure.

The uterus was free in the pelvic cavity, and measured three inches by the sound. She had the facies ovariana. I had no doubt that the case before me was one of cystic disease of the ovary.

February 15, at 2 p. m., was appointed for the operation; sponges, instruments, rubber cloths, and dressings, had been thoroughly carbolized. The carbolic spray had been going on in the operating room for one and a half hours, but was stopped before the operation began. Dr. N. B. Baker (whose patient she was) and Drs. Keyser, Fawcett, and Robert T. Wilson were present, with the two hospital nurses. The patient was given  $\frac{3}{4}$  of whisky, and chloroformed by Dr. Keyser. I again reviewed my former examination, and was satisfied that I had a simple cyst of the ovary, without complications, to deal with.

Not feeling well, nor in an operating humor, I handed the instruments to my son, Dr. Robert T. Wilson, and told him to proceed with the operation. He cut carefully into the abdominal cavity, making an incision of three inches, down to the perito-

neum, and entering the cavity by an opening of about half an inch. Immediately, there was a gush of a greenish-yellow fluid, and turning the patient on her side, about one and a half gallons escaped; enlarging this opening to three inches and looking in, a solid tumor was discovered about nine inches long, six inches broad, and three inches thick. The walls of the abdominal cavity were festooned with recent lymph, and patches of the same were seen everywhere. The hand passed in, found adhesions everywhere. The uterus and ovaries were normal, but we could not determine by the touch and sight what this tumor was, till we had lifted it from the abdominal cavity, and found it was made up of coils of intestine agglutinated with lymph. It was so firm and solid, that at first sight it was hard to believe it a mass of intestines. It was not agglutinated to other abdominal viscera, but seemed to be free in the peritoneal fluid.

Dr. Robert Wilson returned the mass to the abdominal cavity, and closed the abdominal opening with seven silver wires, and dressed the wound as usual in ovariotomy.

Thus the case which I was sure was ovarian dropsy turned out to be localized peritoneal dropsy, the result of peritonitis.

This woman told me before the operation, and has several times confirmed her statement since, that she had never been sick a day in her life, except during confinements, and her youngest child is now two years old. Dr. Baker, who has been her physician ever since her marriage, assured me that her statement was correct.

For my diagnosis I had before me a fluctuating tumor, occupying the lower part of the abdominal cavity, and the abdomen was rounded prominently about the umbilicus. In the dorsal position, it did not bulge out to either side. There was clearness on percussion in both lumbar regions. Changing the position of the patient did not change the lines of dullness on percussion. She had no tenderness on abdominal pressure. All of her organs were acting well, and the pelvic viscera were as they should be in such a supposed ovarian cyst. No anasarca; no edema of lower extremities.

I do not see how we were to avoid falling into the error into which we were led. Had we tapped her (which should never be done in ovarian tumors, if possible) we would have been none the wiser, but would rather have had our diagnosis confirmed by the solid tumor which would have remained. I have not implicit confidence in the ovarian cell as a means of diagnosis.

Dr. Peaslee says in his book on ovarian tumors, "It might be expected that the removal of all the fluid from the peritoneal cavity would at once decide between ascites and an ovarian cyst. But Dr. McDowell and Dr. A. G. Smith had a patient who had tapped herself with a trocar and canula 90 times, in whom, on opening the abdominal cavity to remove an ovarian cyst, they found only a mass of intestines matted together by adhesions."

Dr. T. Spencer Wells in his work on ovarian and uterine tumors says: "The fluid poured out as the result of inflammation of the peritoneum, instead of lying free in the cavity, is sometimes confined in pouches formed by adhesions among the viscera, or by false membrane deposited during the disease, or by attachments of the omentum or mesentery." "The fluctuation, even if distinct, is always limited in extent and confined to the same spots. The intestines are found behind or beside the tumor, and do not as in ascites rise up to the front of the abdomen, or vary with the position of the patient."

(*To be continued.*)

### ALBUMINURIA.

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(Concluded from page 678.)

If, however, the amount is small, but a trace indeed, there may be a condition such as Roberts terms physiological albuminuria; this is a condition of things difficult to recognize; we must find the amount of albumen small; it must not be constantly present, that is, it must be intermittent, absent, for instance, in the urine passed in the morning, but showing itself during the day after food and exercise, as Brown-Sequard has shown its presence after a full meal of eggs; finally the albumen must be long continued. Supposing it to be a normal product, we know, as yet, no way of determining the fact from the discovery of albumen alone, how much shall be looked upon as normal, and when the normal becomes abnormal. We can only determine by a careful inspection of the whole body, and if we find no diseased condition we say the albumen is a normal product; the simple presence of albumen tells us nothing, it awakens suspicion only. Again there seems to be no doubt that many cases looked upon as physiological, if carefully looked into, will be found to depend upon

some systemic fault, not it may be in the kidneys, but elsewhere, as in those broken in health or who suffer from dyspepsia. Dr. Mahomed states that "he found albumen in the urine in 9 out of 58 persons (namely 15.5 per cent.) thought to be healthy, whom he examined for life insurances. It was shown that 7 out of the 9 cases were not in perfect health. At best then physiological albuminuria is exceedingly rare, and a case should not be pronounced such until the fullest examination of the whole body is made. So far as we know now, even a trace of albumen should cause apprehension, and we should not rest until we have exhausted all sources of information as to cause. Dr. Greenfield remarks in this connection, and we heartily agree with him: "There are cases—I have had such under my care—in which there was no evidence of disease beyond the presence of albumen in the urine, and in these cases not merely intermittently, but in one or two cases continuously, during a period of some months, though in variable quantity. In the cases to which I refer there was neither dropsy nor cardio-vascular changes, and none of the serious disturbances which we find in Bright's disease; these subjects were especially anaemic young women."

The urine was usually pale, clear, of low sp. gr., often phosphatic, and contained neither casts nor blood. But are we on this account to say there is no disease, that it is a physiological albuminuria? I believe that, as pathologists, we are bound to allow of no such conclusion without the most exhaustive analysis and conclusive evidence.

If we look at the list of diseased conditions in which albumen may be found in the urine, we will find them almost legion; so many and so diverse are they indeed, that one learns but little as to their nature from the fact that albuminuria is present. This is a symptom of so little moment in many conditions that we do not even look for it. Such is true of rheumatism, ague, measles, etc.; in others, on the contrary, it is eagerly sought for that we may know the tendency of the diseased conditions present, as after scarlet fever and certain forms of Bright's disease; still even here it has but a secondary place, for without the microscope and a thorough examination of the patient, we can learn but little of the actual conditions present. Still further, even in some forms of fatal disease, as after scarlet fever, no albumen may be found, showing that thus, even when you would look most for it, it may disappoint you by its absence. Upon this point Dr. Greenfield well remarks: "It is a well known fact

that extensive disease may exist in the kidneys, remaining for a long time entirely latent, and reveal itself by some terminal fatal phenomena, or be discovered after death. I have for some years made it a special object to examine all kidneys, whether obviously diseased or not, whenever opportunity permitted, more especially in cases of men dying over the age of 30, or dying from acute diseases of all kinds, and have been struck with the frequency with which changes of an extensive character have been found where none were suspected during life."

One needs but glance at the various bodily disorders in which albuminuria exists to see with what comparative ease the urine can be made albuminous; not even a diseased condition need be present—simply throw too much albumen into the blood and in an altered form you will find it in the urine. The pathology of albuminuria is still a somewhat vexed question; the old idea that albumen is thrown out from the blood to be reabsorbed by the cells of the tubuli and so kept from showing itself in the urine having been disproved, has been replaced by that of Heidenhain, who taught that the albumen is kept back by the cells covering the outside of the glomerular tuft; so long as these are in good condition, the arterial tension not too great, and the blood not surcharged with albumen, these tests will fail to show an albuminous urine. Any condition of the cells of the glomerular tuft that will interfere with their function then may cause albuminuria, and as these may be true secreting cells, like those of the salivary and sweat glands, it is not difficult to explain how it is that so many diverse conditions have this one symptom in common.

As with all secreting cells, those of the glomerular tuft are very sensitive to any change in the blood supply to the tuft; thus heart troubles, fevers, inflammation, and that large class of diseases which cause increased arterial tension, will cause these cells to allow the passage of albumen; in the latter case it may be as some one has suggested by a partial tearing of the cement substance that binds these cells together, and thus the albumen escapes.

The cells of the glomerular tuft, if their function is now correctly known, are influenced by the slightest changes, oftentimes, in their blood supply, and the slightest disturbances of the normal circulation will cause albuminuria.

Dr. Mahomed, indeed, looks upon the increase or diminution of the circulation of the blood in the tufts as the two conditions most

likely to produce albuminuria; indeed, they are the chief causes.

Thus the kidneys, like other organs, become congested; this may go no further, or may end in inflammation, and the cells covering the glomerular tuft show circulatory interference by allowing the albumen to pass out; in the one case it soon disappears, in the other it is increased in amount, and frequently the cells become more and more unfit to perform their function, and the first stage of Bright's disease, according to Frerichs, is fairly established.

We had intended to note other points in this interesting part of the subject, the difference in function of the cells of the glomerular tuft and those lining the tubuli, the mode in which the blood-currents influence the presence of albumen in the urine, how it is that the first signs of destructive disease commence in the glomeruli and tubuli, and thus cause albumen to be one of the first symptoms; but our time is already, we fear, more than exhausted.

## MEDICAL SOCIETIES.

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### OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated meeting, Thursday, March 4, 1886.

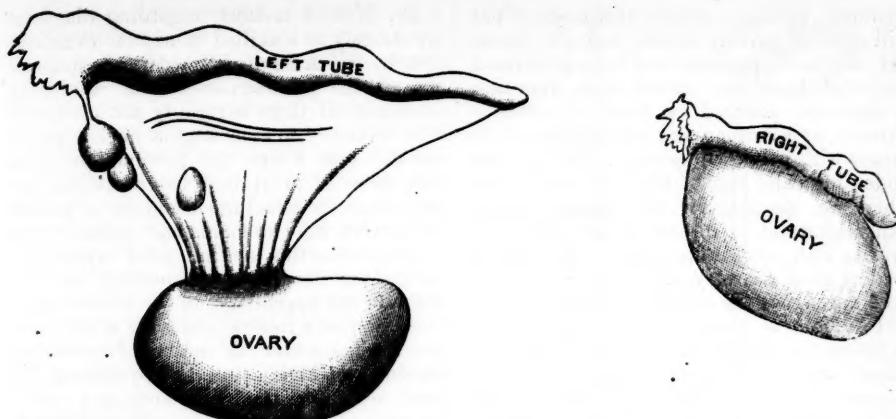
The President, B. F. Baer, M. D., in the chair.

#### Menstrual Epilepsy.

Dr. Howard A. Kelly exhibited recent specimens of tubal and ovarian disease removed within the past two weeks. The first specimens to which he called attention were removed from a patient twenty-one years of age, who has suffered from an aggravated menstrual epilepsy from the very first appearance of the function. There was no difficulty whatever in the removal through a small incision into which two fingers could just be slipped. The whole operation from beginning to complete closure took but twenty-four minutes. The right ovary was deformed by a very prominent nodule, about one and a half centimetres in diameter, which burst on removal, discharging a watery fluid, and was shown by its lining membrane to be the last corpus luteum.

The second specimen are rare examples of *Hydrosalpynx with Congenital Deficiency of Tubes and Broad Ligaments*.

In this case there was malformation of the distal ends of the tubes, broad ligaments, and ovaries. The left tube is as large as a



bologna sausage. It was brought into view with great difficulty, after separating many light adhesions to the pelvic walls; while the isthmus is much enlarged and thickened, the great distention is at the involuted ampulla. The operator was materially assisted in bringing this tube into view by upward pressure on the cervix by a hand in the vagina. The fimbriated extremities were lost in a mass of vascular and fibrous tissue forming a broad ligament, and deep down in this were imbedded the somewhat hard elongated large ovaries. It was utterly out of the question to attempt a removal of the ovaries, and any such operation would have been of a very desperate character; nor did he, Dr. Kelly, regret this in the least, as he had planned his operation for *tubal* disease, to which he attributed all the patient's sufferings. The right tube was as large as his middle finger, and was also distended with watery fluid.

The other specimen is a very large

#### Hematosalpinx.

This tube, the left, about four inches long, burst as he was removing it, discharging four ounces of tarry blood. It was very adherent, having several attachments to intestine and omentum. The dilatation is here too seen to be at the ampulla, which extended far beyond the ovary, back into the cul-de-sac. The ovary is embraced by the isthmus, and presents a curious appearance as it lies, about twice the normal size, imbedded in a sort of a ball-and-socket manner below the isthmus. Where it is laid open, the tube is converted into one large sac.

Dr. W. Goodell had been surprised at the size of the tubes.

Dr. Jos. Price remarked that the tube was so large that the uterus had been pushed

aside by it. Great care was required in its removal.

Dr. Chas. Hermon Thomas said that some time since he should not have recognized such a condition, but now he can; the result of experience in bimanual examination. He would like to hear further on this point of diagnosis.

Dr. B. F. Baer thinks it very unfortunate that the ovaries as well as the tubes could not have been removed in the case just reported by Dr. Kelly, for their presence will probably result in the usual monthly congestion, and consequently the pain and other pelvic distress, for the relief of which the operation was performed, may continue to exist. There are several cases on record in which the tubes were removed and the ovaries allowed to remain, but the results have not been reported. He can see no reason why this should be done, unless the ovaries can not be found, or some other insurmountable difficulty presents itself. He fully believes in the advantages of prolonged and thorough palliative treatment in these cases. Benefit usually follows, and sometimes cure; at least operation is rendered less difficult and more likely to be followed by recovery of the patient, both from the operation itself and the symptoms. Certainly the application of remedies such as iodine to the fundus of the vagina and the interior of the uterus, with prolonged rest and general building-up of the system, will have a strong influence in attenuating adhesions, promoting absorption of lymph, and possibly, if not probably, in cure of the patient without operation.

It should not be forgotten that removal of the tubes and ovaries in these cases does not cure absolutely in every case. He believes that we will be called upon in a few years by many of these cases which have been

operated upon, to relieve symptoms which still exist or have returned, and for the relief of which operation had been performed; just as we have been called upon from time to time and pestered by those old cases of chronic hypertrophy and retroflexion of the uterus with pelvic adhesions. He has now under his care one of his own cases upon which he operated for the relief of symptoms, the result of disease of the tubes and ovaries with pelvic adhesions. The patient made a good recovery, and appeared to have been cured, but the symptoms have returned, and she is now complaining almost as much as before the operation. She also has periodical attacks of metrorrhagia. This of course is an unusual case. He has another patient under his care, who was operated upon in a neighboring city by removal of the tubes and ovaries, and is treating her for the same symptoms of which she had complained before the operation. He is an advocate of the operation in some cases, but he pleads for due deliberation and the exhaustion of careful palliative and preparatory measures before operation is resorted to. Many cases will get well without operation. Some will not be benefited before operation is performed, and there is some danger in laparotomy, although Tait has had such remarkable success.

Dr. Da Costa inquired if Dr. Kelly had tried the benefits of rest and treatment before operating.

Dr. Joseph Price said that the recurrence of symptoms seemed to indicate partial removal of the tubes and ovaries. One of the fundamental rules of surgery is to seek for pus where it is probably present, and in all cases to remove it if possible. When the ligatures will cut through the tubal stump on account of its cheesy character, hemorrhage may be prevented by the application of the cautery.

Dr. Kelly, in closing the discussion, said he did not in the least regret that the ovaries could not be removed, as he had operated for tubal disease, not for ovarian; and he admired the zeal of Schröder, who instead of always removing the ovary, sometimes resected diseased portions. In all the cases of tubal and ovarian disease upon which he had operated, months and years of careful treatment had been wasted; and now where he diagnosticated pyosalpinx, the only delay he allowed was to put the patient in the best possible condition for operation. Topical, external, and internal treatment is utterly futile, and never does more than secure temporary palliation.

Dr. Kelly's reliance regarding diagnosis lay entirely in a skilled bimanual examination, by which he always accurately mapped out all the peculiarities of the case before operation. If there is rigidity and resistance it is necessary to etherize, but he has yet to see the case where the presumptive signs were those of tubal and lesser ovarian disease where the structures could not be picked up between the two hands and outlined. He considers that this tact has been largely developed by persistently examining the condition of the appendages to the utmost possible extent as a routine practice, in all cases which come under his notice. Introducing the finger as high as possible by forcing the hand well under the pubic arch, and carrying the sensitive pulp up against the postfornix or either lateral fornix, and then playing up and down with the other hand pressing on the abdomen and creeping a quarter inch at a time without ever fully relaxing, and letting structures in between roll through the two fingers, and in case of an ovary, running round its whole periphery, or of a tube, tracing it up to the cornu-uteri and down into the retro-uterine pouch, where it generally terminates, give often most surprising results, and would doubtless, if universally carried out, change hundreds of diagnoses of leucorrhœa, endometritis, and flexions with adhesions to the far more serious ones of pyo- or hemato-salpinx.

#### Pyosalpinx.

Dr. Joseph Price exhibited specimens of pyosalpinx from two patients, and afterwards remarked that Tait and Keith have ended the dark period by showing us how to operate on the abdomen and pelvis without fear and with little risk. The wonderful advance in pelvic and abdominal surgery should be placed to their credit. He believes it is now universally admitted that they have reached the very acme of perfection. One surely must be a convert to Tait's law to contend with the great difficulties in pelvic surgery—"That in every case of disease in the abdomen or pelvis, in which the health is destroyed or life threatened, and in which the condition is not evidently due to malignant disease, an exploration of the cavity should be made." Standard works on ovariotomy dwell at great length on the subject of adhesions as the most important and difficult complication with which the operator has to contend. In short, in pelvic operations the risk and the difficulty will ever lie in the separation of organized inflammatory products. Adhesions, when old, between the pelvic viscera

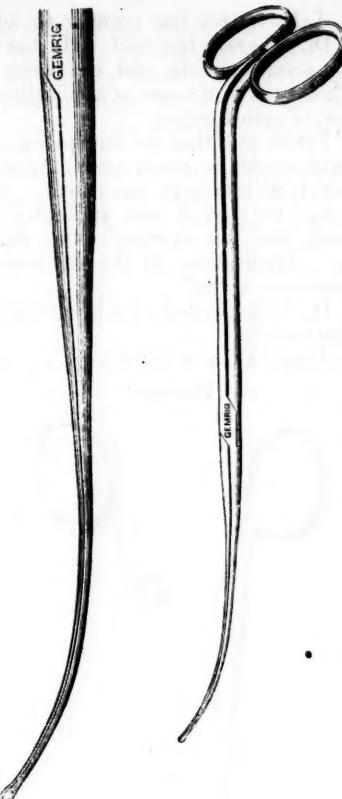
and diseased tubes, become degenerate, and hence easily ruptured. In one case only have strong adhesions, deep in the pelvis, stayed my hand. The right tube and ovary adhered strongly to the sac and right side of the uterus, and the whole adherent mass was absolutely inseparable. Again, the rupture of pus tubes or cysts filled with inflammatory, septic, or malignant elements, will be followed by serious symptoms. Operation becomes difficult when the ovaries and tubes, tightly distended with pus, and softened through pathological changes, cheesy in consistence, are matted together with the rectum and small intestines.

#### Uterine Applicator and Dressing - Forceps Combined,

exhibited by Dr. Charles Hermon Thomas.

This instrument, which is especially adapted to making applications within the cavities of the neck and body of the uterus, but which is also available for making dressings and applications to the vagina and external surface of the cervix, has borne the test of two years' use. It is in forceps form, the blades are strong and resistent from the handles forward about two-thirds of their length, when they narrow rapidly, so that taken together they become about equal in size to the ordinary uterine sound. This narrow portion, somewhat suggestive of the long beak of the angular ear-forceps, is about three and a half inches in length, the tips being roughened on their opposed surfaces. It holds securely the smallest peldorf of cotton, and by reason of the springy character of the beak, will permit the locking of the handles when a full-sized peldorf or tampon is placed within its grasp. The point is slightly probed, as an extra precaution when introduced to the uterine fundus, though a small cotton ball answers all needed purposes as a protective tip. I have usually employed the plain point on account of its occupying less space at the internal os uteri. The beak is curved to a shape corresponding very closely to that of Ellinger's dilator, which has been found so generally well adapted to entering the uterus. This portion is electro-plated with gold when so ordered (a proceeding of moderate cost and to be commended), as a protective against the corrosive action of iodine, iodized phenol, and the like, which so rapidly destroy nickel-plating and corrode polished steel surfaces. This instrument was made under my directions by J. H. Gemrig & Son, of this city.

Some practical points of use may be mentioned. Soiled or medicated cotton is easily removed with the use of one hand only, by



simply unlocking the handles and wiping the point in a crumpled paper, thus leaving the other hand free for other employment, and avoiding the trouble, the soiling of the fingers, and the whittling often involved when the wire applicator is used. In its use there is immunity from the rasp action of the closely wrapped cotton of the wire applicator, and also a greatly increased carrying capacity of the cotton for medicated liquids. Moreover, it will be found convenient and desirable to make use of the instrument as a uterine sound incidentally in certain instances. In my own experience it has proved practicable as an applicator, one fully meeting the needs of most cases, while it has been found so satisfactory as to have superseded all other instruments of this class.

Dr. Baer said the instrument presented by Dr. Thomas is a very ingenious one, and will doubtless serve a good purpose where the cervical canal is patulous. A greater quantity of the medicating agent used can be carried to the diseased surface than when the tightly wrapped cotton is used.

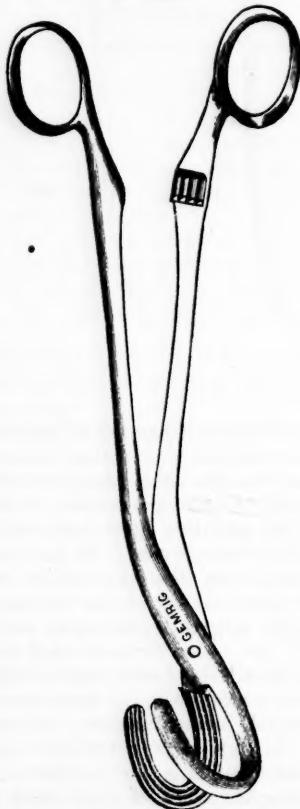
Dr. J. F. Wilson has nothing to add to what Dr. Thomas has said. He has used one for several months, and can agree with Dr. Thomas as to the ease of application and removal of soiled cotton.

Dr. Parish said that the forceps was valuable, and would be much used. As an applicator it will be very convenient. A few years ago the sound and applicator were too much used, but extremes either way are wrong. Applications to the endometrium are sometimes needed.

Dr. H. A. Kelly said this is a very valuable instrument.

Dr. Joseph Price exhibited a

#### Forceps



for the complete closure of the trocar puncture in ovariotomy.

Dr. Parish exhibited a specimen of

#### Ovarian Tumor,

removed the previous day. The symptoms had been very peculiar, and the form of the abdomen was misleading, there being a deep groove across the hypogastric portion of the tumor. Numerous adhesions gave great

fixity. These adhesions embraced the colon, parietes, and bladder, and were old and dense. Its rapid growth had raised a question of malignancy. A great portion of the tumor was solid.

Dr. Harris remarked that a microscopic examination of the tumor should be made. There had been great difficulty in diagnosis as to the origin and character of the tumor. A slight fluctuation could be detected in the lower portion under the use of an anæsthetic. There had been no uterine symptoms, and menstruation had been regular. The long fallopian tube crossed the tumor and made a deep constriction across its middle.

Dr. Baer did not think rapid growth a proof of malignancy. He had seen five or six cases of very rapid development; one in three months contained a bucketful of fluid. In none of these cases has there been any return or other sign of malignancy. The presence of papillomatous growths within the cyst is no proof of malignancy.

W. H. H. GITHENS, *Secretary.*

#### CLINICAL SOCIETY OF MARY-LAND.

Stated meeting, held April 2d, 1886.

Dr. O J. Coskery read some notes from

#### A Case of Artificial Anus.

Dr. S. T. Earle called attention to a case similar to that of Dr. Coskery, reported in the *London Lancet* for May, 1885. The operation terminated fatally because of the puncture of the peritoneum. He asked if the plan advised of dissecting out the coccyx and turning back the rectum was not the preferable way of relieving these cases.

Dr. Randolph Winslow said it seemed to him that a cutting operation, the splitting of the anus to the coccyx and if necessary the removal of the coccyx, and the bringing down of the rectum and uniting it with the anus, would have been much more satisfactory in its results and much less severe on the child, than the method pursued in this case. Even if the bowel was fortunately entered by the trocar without injuring some of the neighboring viscera of the peritoneum, the difficulty of keeping a hole, tunnelled through the tissues, patent, was a very great objection to the method. As was well known, the parents of a child would be likely to neglect systematic dilatation, and the channel would close as it had done in the case reported three times already. When the mucous membrane of the rectum can be attached to the anus, this tendency to contrac-

tion is nearly overcome. If it is impossible to attach the rectal mucous membrane to the skin, a colotomy would probably be the preferable operation.

Dr. Coskery thanked Dr. Earle for calling his attention to the article in the *Lancet*.

The course pursued by him in his operation was the one desired by the parents of the child. He gave them their choice of the operations, and they united upon the least bloody one being done.

Were he called upon to do the operation again, he would adopt the plan of drawing down the rectum and uniting it to the external surface. He did not understand how Dr. Winslow could prefer a colotomy, when often by an incision two inches deep one could easily enter the rectum.

Dr. Earle, in speaking of the adhesions so often met as an obstacle to drawing down the rectum, gave as his opinion that they are not congenital, but are rather the result of manipulation with trocar and canula.

Dr. John Morris, while in the Dublin Rotunda, saw two cases of congenital imperforate anus. In one, there was a *cul-de-sac* leading a short distance into the soft tissues, and in the other there was but a depression at the point where the anus should have been. Both cases terminated fatally. The latter one was operated upon after the trocar and canula method, and at autopsy the bladder was found to have been punctured.

Dr. Joseph T. Smith then read a paper on *Albuminuria*. (See page 676.)

Dr. J. H. Branham said that Dr. Smith's statement, that the cells covering the glomeruli had a secretory function, was contrary to what he had been taught. He took them to be only a flat epithelial covering, purely mechanical in their function. They acted, according to his ideas, as a filter, through which the watery and saline elements of the urine exuded. The cuboidal cells lining the tubes, he thought the true secretory elements.

Dr. I. E. Atkinson considered the comparative anatomy and physiology of the kidneys in different animals a very interesting study. For example, in birds, where there is no passage of true watery urine, the tubes are very long and convoluted, thus admitting of the reabsorption of the watery elements, and the passage of the solid constituents as solids; in fishes we see just the reverse; here there is no retention of the watery portion, and we find the tubes straight and simple, admitting of the passage of the urine just as secreted.

He believes the epithelium covering the tufts different from that lining the tubes; he does not consider it a true secretory structure, and does not think that the cuboidal cells of the tubes are the secretory elements of the kidneys.

Nitric acid and heat, or Heller's test of nitric acid alone, he thinks sufficiently accurate for all practical purposes in detecting the presence of albumen in the urine. Uric acid is sometimes thrown down, but this is easily recognized. A rather more convenient form in which reagents may be carried about, he finds in the test papers prepared by Parke, Davis & Co. They are handy, and he has found them tolerably accurate.

Dr. C. O. Miller referred to the experiments done upon the frog in Heidenhein's laboratory, in which it is shown that the epithelium covering the glomeruli have a true selective action. He thinks, however, that an objection of some weight may be made by the possible degeneration of the cells caused by the injection mass employed, and thus their true function altered.

Dr. Joseph Blum has employed the test papers referred to by Dr. Atkinson, and finds that, excepting the picric acid ones, they all deteriorate after a time.

Dr. J. H. Branham read a paper on *Perineorraphy*.

Mary Johnson, col., age about 20 years, was confined on December 1st, 1886. The position was right posterior and the child was large.

The second stage of labor lasted for nine hours, and was finally terminated after great difficulty by the use of forceps. Notwithstanding great care exercised by a skillful operator, an extensive rupture of the parts occurred.

I first saw the patient about two hours after the labor was completed. The rupture included the perineum, the posterior wall of the vagina to the extent of two and a half or three inches, and an inch and a half of the rectum. It began in the middle below, and extended upward and to the right.

The tear through the perineum was ragged, and the sides were trimmed before bringing them together.

Three rows of sutures were used, one in the vagina, one in the rectum, and the other in the perineum. Some difficulty was experienced in introducing the high vaginal sutures, otherwise the operation was easy.

Before introducing the sutures the parts were thoroughly cleansed by bi-chloride solution, strength one in two thousand parts of water. Small iron wire was used for sutures.

After the operation a rubber tube with a number of openings in it was introduced into the vagina, the distal end being in a bottle of bichloride solution. This acting as a siphon carried off the lochia almost entirely. Parts were disinfected twice daily by fluid passed through this tube, bichloride being used part of the time. Bowels were closed by opium during first six days, liquid food being given. Patient did well, highest temperature being 102° on fifth day.

Sutures were removed on twelfth day, when good union was found, all the tear being healed except at the back part of ostium vagina and fourchette. The union was partly by first intention and partly by granulation.

What is the prognosis of primary operation in complete rupture?

Tait says: "If the case be seen immediately after the rent has been made, stitches may be applied without any preliminary paring; but this practice has never had a satisfactory result in my hands; for in all the cases where I have been called in to perform it, the tissues have been so bruised and the edges have been so ragged that a satisfactory union has never been effected save by a subsequent operation. It is, however, worth trying.

"Others have met with little better result. I attribute the success in this case to drainage and antisepsis, and think that unless such measures are carried out there is little chance of a good result. The vagina tends to dilate and the lochia to collect in it, when, unless some means are employed to prevent, it undergoes decomposition and prevents union.

Dr. W. Pawson Chunn: Was there any recto-vaginal fistula?

Dr. Branham: None whatever.

Dr. Chunn: What was the object of stitches in the rectum?

Dr. Branham: The rectum was lacerated for one and one-half inches, and the stitches were put there to restore this laceration. Their twisted ends were on the mucous surface of the rectum, and they remained in position for twelve days.

Dr. Chunn said his reason for asking so particularly about the stitches in the rectum, and the position of their twisted ends, was that such efforts were usually not so successful as Dr. Branham's had been. The plan usually adopted with success was to twist the wires on the mucous surface of the vagina.

Dr. Randolph Winslow thought Dr. Branham could scarcely claim much of the good result attained in his case as due to the antisepsis, which seemed to him to be very

defective, being antiseptic only when the irrigations were being practiced, with an abundant opportunity for the entrance of germs in the intervals. After considerable experience in perineorrhaphy, Dr. Winslow had discarded wire sutures entirely, and now used antiseptic silk. The results were equally as good, the difficulty of introduction and removal of stitches very much less, and the comfort of the patient much greater. In cases in which women have been operated on twice, once with wire, the second time with silk, they express themselves strongly in favor of the latter. The continuous cat-gut suture is probably better than either, as the necessity of removing the stitches is thereby avoided.

#### Foreign Body in the Nose.

Dr. John N. Mackenzie relates a case of foreign body in the nasal cavity of a child, the removal of which was facilitated by the use of cocaine. Dr. Mackenzie regretted to be obliged to intrude upon the Society's time by bringing before them the much talked over cocaine, but in this case it proved itself of so much service that he considered himself justified in calling attention to its value in such cases. When he saw the child there was a bit of bone very tightly wedged between the corrugated mucous membrane. An attempt to remove it with forceps failed. He applied cocaine to the tissue in order that its power of causing contraction might lessen the pressure and enable him thus to remove the foreign particle. This effect was produced in a few minutes, and the bit of bone was easily removed.

Dr. H. Clinton McSherry had been in the habit of using cocaine with most happy results in obstinate cases of epistaxis.

#### Gonorrhœal Ophthalmia.

Dr. Samuel Theobald referred to a case of gonorrhœal ophthalmia that he had recently seen. When the patient presented himself the left eye only was affected, and had been so for three days. The lids were swollen, ecchymosis was present, and the cornea was sloughing at its upper margin. Right eye was at this time entirely free from this trouble. In spite, however, of every precaution, the right eye took on a similar condition. Treatment was at once instituted. The eye was painted over once daily with a 15 grains to  $\frac{3}{4}$  of nitrate of silver solution, three times daily with a 2 grains to  $\frac{3}{4}$  of the same drug. After each application the silver was washed away with sodium chloride solution.

Besides this, boracic acid solution was instilled every four hours, and atropia em-

ployed daily. The left eye is lost. The right eye is entirely under control. This the doctor attributes to prompt treatment. He thinks had the right eye gotten fairly underway, that it would have been destroyed.

#### Hemichorea and Hemiplegia.

Dr. Preston related a case of a girl whom he had recently seen. She had hemiplegia

on one side and hemichorea on the other. The chorea came first, and was followed by the hemiplegia. He thinks the chorea was caused by a minute embolus, and the hemiplegia was the result of the consequent softening or by a second larger clot. He considered the case interesting, as probably shedding some light on the pathology of chorea.

## EDITORIAL DEPARTMENT.

### PERISCOPE.

#### Case of Intercurrent Hepatitis and Retained Gall-stones.

Dr. Alexander Napier thus writes in the *Brit. Med. Jour.*:

Mrs. W. T., aged 43, had been subject to occasional "biliary" seizures for at least six years, and to a tendency to prolapse of the womb for several years; for the latter affection she wore a pessary. She stated she had "gastric fever" twice, once twenty-three years ago, and again fourteen years ago; she was five weeks in bed in the last attack, not so long in the first.

With the exception of the "biliaryness" referred to, there was no indication of grave involvement of the liver till June 21, 1884, when Mrs. T. suffered from well marked symptoms of hepatitis; acute pain in the right hypochondrium, enlargement of the liver, feverishness, nausea, and sickness, but no rigors, and no jaundice. She was confined to bed about two weeks. Mrs. T. then continued tolerably well, with occasional "biliary" attacks, always with want of appetite, till May, 1885, when she had another similar illness (apparently hepatitis), but much slighter, lasting only a few days.

In the end of July or beginning of August, 1885, she received a severe blow with a tennis-ball in the pit of the stomach. This caused intense pain at the time. From this date onwards the general indisposition, and the uneasiness in the region of the stomach, increased; there were a constant, dull, heavy pain in the hepatic region, entire loss of appetite, and progressive debility.

On September 10, 1885, the pain suddenly became very acute, and was accompanied by sickness and vomiting, which lasted for three days; this was followed by marked jaundice, the urine becoming very dark in color, and

the stools white, or pipe-clay colored. The patient at this time was twelve days in bed, but the jaundice did not disappear till six weeks had elapsed. She then improved a good deal in general condition, and suffered no longer from headache or sickness, but there was still entire absence of appetite.

On November 18th, 1885, there was another sudden attack of severe pain in the hepatic region, which had been preceded for a day or two by an increased sense of uneasiness in the liver. It was then that I saw her for the first time. The attack was one of typical gall-stone colic; the pain was spasmodic, exceedingly severe, shooting up to the shoulder and through to the spine, causing the patient to cry out; it was accompanied by marked and severe rigors, and by vomiting. Pulse 96; skin cool; tongue whitish and moist. Relief was obtained from the use of morphine subcutaneously.

After the first night, the pain was not so severe; but the liver continued tender to pressure. The irritability of the stomach lasted for several days, only small quantities of liquid food being tolerated. Then vomiting ceased; the pulse rose to 120, and the temperature to 100° and 101°, for many days in succession; marked jaundice came on, with constipation, whitish stools, very dark (almost black) urine, headache, and nausea. The liver was tender to pressure over the left lobe and over the region of the gall-bladder; in the latter situation, a well-defined rounded mass could be felt. Hepatic dulness was not perceptibly increased in the axillary line, nor over the left lobe; but at the median edge of the right lobe, in the region of the gall-bladder, it came far past its normal limits downwards, exactly corresponding to the firm mass above referred to. The swelling was smooth, firm, and resistant, but gave no sense of fluctuation, or of rubbing when grasped.

Treatment consisted in the use of morphine at first, to relieve pain, the occasional administration of saline purgatives, chloride of ammonium, and pancreatized food, together with persistent poulticing of the hepatic swelling.

The patient was seen early in December by Professor Gairdner; he, without rejecting the theory of gall-stone, rather favored the view that we had to do with an abscess or tumor of some kind.

The patient's general condition gradually improved, though the mass projecting from the lower border of the liver continued rather tender to pressure, and quite unaltered in size, till January 8, 1886, when she had a severe rigor, vomiting, and acute hepatic pain; while the mass became distinctly larger, and much more tender. The skin and superficial tissues were freely movable over the swelling. Pulse 120; temperature not noted, but certainly not febrile. In a couple of days the pulse had fallen to 90, the sickness had ceased, and the local pain much diminished; this attack passed off without any jaundice.

On January 18th the patient complained much of severe darting pains, with considerable tenderness to pressure over the whole abdominal surface, not specially over the swelling, though this continued tender. These pains, probably connected with the formation of adhesions between the swelling and the abdominal parietes, lasted for several days, but yielded to persistent poulticing.

On January 22d she was ordered capsules containing ether and turpentine.

On January 25th there was slight vomiting once, and the capsules were stopped.

On January 27th very severe and persistent vomiting set in. Absolutely nothing, not even a drop of water or broken ice, remained in the stomach. The pulse ran up to 135, and the patient became exceedingly prostrate. She was supported by nutrient enemata.

On January 29th she was seen by Professors Gairdner and Buchanan, and was apparently sinking. The general abdominal pain had gone, but the tumor was unchanged in character, except that it felt more adherent to the skin. It was agreed that the swelling should be opened next day. Morphine, given subcutaneously, procured for the patient a fair night's sleep; and small quantities of milk and brandy were retained by the stomach.

On Saturday, January 30th, Professor Buchanan performed the operation.

#### Congenital Strictures of the Rectum in the Adult.

Prof. Trélat, in a clinical lecture at the Hôpital de la Charité, calls attention to a class of cases of rectal stricture which have been little considered if not wholly overlooked by surgeons heretofore, viz., congenital strictures, the symptoms of which do not attract attention until adult life.

These strictures are valvular in form, thin and sharp, and are situated three to five centimetres from the anus, corresponding to the point of blending of the rectal cul-de-sac with the cutaneous depression in the process of development. He is disposed to regard all such strictures, so situated, as being congenital in their origin.

The mode of commencement of the grave symptoms is various. Sometimes a patient reaches the age of forty or more years without having experienced the least irregularity in the intestinal functions; sometimes there are in infancy transient, intermittent phenomena, which become serious at a remote epoch. A third category includes those in whom during their whole life there are more or less serious intestinal disorders.

While he recognizes the difficulty or impossibility of satisfactorily accounting for the appearance of these manifestations, or their intermittent character when the causative lesion is a permanent one, he calls attention to the fact that this is by no means an exceptional case in this regard—that there are various other affections of congenital origin which demonstrate their presence only in adult life.

As to this particular feature it is easy to understand that during early life it is simple, extensible, with no induration, perhaps even less close and narrow than it will be later. The abdominal muscles have all their vigor, and the intestinal, biliary and pancreatic secretions are abundant, making all the physiological conditions for easy defecation. But as age advances, an induration of the valvular fold takes place, the muscles become weakened, the intestinal walls are less lubricated, the fecal mass less softened, and the lesion, previously innocent, produces a trouble more and more pronounced.

Thus there may be inflammatory troubles, and consecutive fistulae. The site of these last is constant: they are situated above the stricture, and are due to the valvular lesion itself.

This complication is frequent, but there are others more serious, whose course is the same; the obstruction offered to faecal matter by the stricture, and the changes of the

rectal mucosa above the valvula, create a constant inflammatory state which results in perirectitis, adenitis, gangrenous phlegmons of the pelvis, finally interstitial nephritis and sclerous hepatitis, which seem to be consecutive to these peri-rectal phlegmasias.

Prof. Trélat urges the importance of early diagnosis, inasmuch as the lesion itself and its effects become more and more serious as time advances. He says that examination by rectal touch should be practiced on the first indication of obstruction.

The prognosis is grave, by reason both of the serious accidents which the lesion causes and on account of the nature of the treatment demanded.

The best mode of treating these affections, even when discovered early, Prof. Trélat does not think has yet been established.

#### Hodgkin's Disease and Its Consequences.

Dr. John Taylor thus writes in an English journal:

The following case, having a fatal issue, presented peculiar features, which may probably be worthy of record:

C. S., aged 14, had not been in good health for some months, although there was nothing in particular to cause anxiety. He had been observed to be out of breath on exertion, to have lost his appetite, and to be frequently craving for water. He had never suffered from ague or fever; he had no cachexia, was fairly nourished, and had never had any hemorrhage from his nose or gums. About a fortnight before the accession of marked illness, he got into trouble in snowballing, and this led him to suffer a somewhat severe chastisement. The symptoms attending his last few days of illness were so unusual and unaccountable that it was suggested that ill-treatment might have caused or accelerated the fatal termination; moreover, exaggerated rumors were abroad as to the injuries he had received. Under these circumstances, it was deemed unadvisable to certify without referring to the coroner, who very properly directed an inquiry to be held and a post-mortem examination to be made.

C. S. was first seen on December 21, by my partner, Dr. Hoar, who found him suffering from gastric disturbance, coated tongue, foul breath, etc., but with a normal temperature, and no symptom of an alarming character. On the 23d, his urine was noticed to be pinkish in color, from admixture of blood, and, of course, loaded with albumen; but he was cheerful, sat up in bed, and played the

flute; vomiting supervened. On the 25th, convulsions set in, and on the same day he died.

The post-mortem examination was performed by Dr. Hoar and myself on the 27th. There were two bruises observed on the left arm, but no further evidence of external injury. In the anterior mediastinum was found a diffused ecchymosis; the heart-substance was pale, but apparently healthy; both ventricles were full of blood. The pericardium contained about two ounces of serum; the lungs were crepitant throughout. On opening the abdomen, the spleen was noticed to be enlarged, and, on further examination, it was found to be four or five times its normal size; the liver was enlarged, extending about three finger-breadths below the margin of the ribs. The stomach and intestines showed no evidence of disease, but there was a general and considerable enlargement of the mesenteric glands. On the posterior surface of the right kidney were two ecchymosed patches; its pelvis was full of extravasated blood, as was also that of the left kidney. On removing the calvarium, the dura mater was found healthy; the vessels of the surface of the brain were congested. There was no evidence of inflammation within the skull, either past or recent. The fourth ventricle was full of extravasated blood. Both lateral ventricles were filled with a large and soft coagulum, breaking up the brain-substance in its neighborhood; the brain itself was healthy. The superficial lymphatic glands throughout the body were, more or less, enlarged and indurated; the submaxillary on both sides, the concatenate, a row of inguinal glands on each side, stood out prominent and distinct; the deep glands in Scarpa's triangle were also affected. On section, the glands presented a greyish surface, and appeared to be simply hypertrophied; no morbid deposit in their substance was discernible.

#### The Seasonal Prevalence of Pneumonia.

We are indebted to Dr. Seibert of New York for having more than once directed attention to the close relation existing between those meteorological conditions which favor catarrhal affections and the occurrence of acute (fibrinous) pneumonia. At the present day, when the specific nature of this disease is receiving so much confirmation, it is specially useful to have the question viewed from another side. In his latest contribution to the subject (*Berl. Klin. Wochenschr.*, 1886, No. 17), Dr. Seibert affords conclusive evidence of the above-named con-

nection. His material was obtained by a collective investigation of returns furnished by members of the New York Medical Society, from March 1st, 1884, to March 1st, 1885. They comprise 768 cases of primary pneumonia, distributed in the various months as follows: January, 71; February, 140; March, 103; April, 73; May, 55; June, 37; July, 26; August, 25; September, 48; October, 62; November, 65; December, 78. A comparison with the average temperature of these months shows a striking correspondence between the lowness of temperature and prevalence of pneumonia; and a similar correspondence is manifested with respect to rainfall, except in the summer months, when, in spite of great humidity, there was a minimum of pneumonia. It is also shown that the prevalence of bronchial catarrh closely coincided with that of pneumonia. Dr. Seibert has not, however, been contented with these general monthly returns, but has placed side by side the results of daily meteorological observations and the date of occurrence of cases of pneumonia during each month of the year. The chart compiled from these data for the month of February will be found in his paper; and it is remarkable how closely the onset of pneumonia follows upon days in which there were combined low temperature, excessive humidity, and high winds. Without attempting to give examples of these relations, it must suffice here to allude to the conclusions at which Dr. Seibert arrives. These results are to the effect that the varying prevalence of the disease can be explained by certain meteorological states which favor its occurrence. These conditions are a low and falling temperature, an excessive and increasing humidity, and high winds. When any two of these factors concur, pneumonia prevails to a greater extent than when only one of the factors is present; whilst if all three factors are in operation, then pneumonia is exceptionally frequent, the frequency lasting as long as the meteorological conditions obtain. The same states of weather favor catarrh, and catarrh predisposes to pneumonia. That pneumonia is more prevalent in spring than in autumn is due partly to the greater liability to exposure after residence in hot and ill-ventilated rooms during the winter, as well as probably to the greater humidity of spring. Finally, the author does not wish it to be inferred that these meteorological conditions are the sole factors at work in exciting pneumonia; his opinion rather is that by exciting catarrh they render individuals more vulnerable and susceptible to the influence of the

pneumonic virus. In this way his observations can still be made to harmonize with the doctrine of the specific nature of pneumonia.

#### Observations on Feigned and Artificial Eruptions of the Skin.

Dr. W. A. Hardaway thus concludes an article in the *St. Louis Courier of Medicine*, for May:

In conclusion, I would beg leave to indicate a few of the points which should be borne in mind in making the differential diagnosis between the so-called feigned and artificial eruptions and the substantive diseases of the skin. In the first place, we should ascertain the antecedents of the patient, and take particular note of the present condition. Secondly, we should discover if the patient had ever suffered from any skin disease before, and whether the patient had been or was at the time making use either locally or internally of any medicinal preparation. We should compare the lesions present with otherknown eruptions of the skin, and make particular note of any anomaly. We should investigate closely the local expressions of the disease, for instance as regards infiltration, itching, burning, etc. It must be borne in mind that most eruptions produced with intent to deceive, generally occupy situations most accessible to the patient, and in the majority of cases, in right-handed persons, are apt to be on the left side of the body. It would be tedious to enter into the minute details of the differences between these feigned eruptions and those due to disease, as, for instance, how a pemphigus bleb will have a certain definite outline, and a bleb produced by nitric acid is apt to be jagged and irregular or linear, but I think enough has been given to show in a general way the cautions to be observed in coming to any conclusion in regard to a suspicious eruption. The late Dr. Tilbury Fox has pointed out that so far as the simulated skin affections are concerned they generally are of the following forms: The eruption is in erythematous or excoriated patches, such as may be produced by rubbing or by mustard; or bullous, or pustular, or more or less deeply ulcerative, and such as could be caused by the application of cantharides, croton oil, or some corrosive acid; or such an eruption as could be brought about by the constant forceful use of the finger-nails; or it is a pigmentation—e. g., simulating chromidrosis, produced by black lead, candle black, grease, and other compounds.

## REVIEWS AND BOOK NOTICES.

## NOTES ON CURRENT MEDICAL LITERATURE.

—The *Medical Review*, of St Louis, appears with an advantageous change in appearance. It is issued under the supervision of the Medical Press Association, and is a valuable periodical.

—Under the title "A Year's Work on Laparotomy," Dr. William Goodell, of Philadelphia, gives a brief resume of the number of cases he has operated upon within this period, with statistical tables, etc.

—The annual report of the Cincinnati Sanitarium for 1885 shows the institution to be in a flourishing condition. The superintendent is Dr. O. Everts, College Hill, Ohio.

—The progress of Electrolysis in Surgery is briefly set forth by Dr. Robert Newman, of New York city, in a paper of eight pages.

—One of the recent articles on cocaine is by Drs. J. Baratoux and E. J. Maure (*De la Cocaine*, Paris, 1885). It is the reprint of an article read before the Société Francaise d' Otologie et de Laryngologie.

—The First Annual Report of the Pathological Department of the Norristown Pennsylvania State Hospital for the Insane, by Drs. Dercum and Reel, contains the report of a number of autopsies of great interest to alienists.

—Dr. Henry F. Campbell, of Augusta, Ga., forwards a reprint of his article read before the American Gynecological Association on the value of the genu-pectoral position in impeded uterine reduction, and in the prolonged nausea and vomiting of pregnancy.

## BOOK NOTICES.

**The Methods of Bacteriological Investigation.** By Dr. Ferdinand Hueppe. Translated by Hermann M. Biggs, M. D. Illustrated. 8vo., clo., pp. 218. New York : D. Appleton & Co., 1886.

The author of this work, Dr. Hueppe, is one of the most brilliant disciples of Koch, and in this volume he has given in detail the methods employed in the laboratory of that celebrated bacteriologist. He indeed claims to do more, and to present a historical survey and criticism of the whole subject. But it is quite evident that this claim is not well

founded, as he scarcely goes beyond the Germans in his quotations, and passes over the French writers generally without any mention. It is therefore a description of the Koch plans, and little more.

He begins with the forms of bacteria and the technique of microscopical manipulation. From these he passes to culture methods and inoculations, to general biological problems, and to special hygienic investigations. As a hand-book in this novel and promising branch of science it is one of the best which has yet appeared, and should be in the library of every student of the subject.

**Seventh Annual Report of the Board of Health of the State of Illinois.** 8vo., pp. 623. Springfield, 1885.

This compendious report gives full details of the proceedings of the Board, vital statistics of the State, decisions under its laws regulating medical practice, information on medical education in the United States and Canada, etc., etc. These materials are carefully arranged and presented, and some of them have already been referred to in other connections. Altogether, the volume is a very satisfactory one.

**Proceedings of the Nebraska State Medical Society.** 17th Annual Session. 8vo., pp. 385. Lincoln, 1885.

A favorable impression is created by this volume through the neatness of its manufacture, and this impression is strengthened by an examination of its contents. The proceedings of the meetings of the Society are chronicled, and a number of reports and original articles of decided merit are added. A somewhat new feature is the prominence given to the reports of delegates from other states and from foreign countries. The addition is a good one, and tends to foster the comity of science which every one should desire to see maintained.

**Drainage for Health, or Easy Lessons in Sanitary Science.** By Joseph Wilson, M. D. Second edition. Illustrated. 8vo., cloth, pp. 72. Price \$1.00. Philadelphia : P. Blakiston & Co., 1886.

The author in these chatty and agreeable pages conveys a large amount of instruction in so pleasant a style that one insensibly continues the perusal of his sentences, no matter where one opens the volume. He discusses land drainage, the drainage of cities and of houses, and adds some sound advice about plumbing. The present edition has received important additions, and will be found a valuable hand-book to the general reader as well as to the physician.

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SULPHATE OF SODIUM.

Especially in our country, whenever a neutral salt seems indicated as a purgative, Epsom salt—sulphate of magnesia—is usually the remedy employed, while sulphate of sodium—Glauber salt—is neglected. One reason for this may be found in the fact that Glauber salt is very cheap, and that it is used mainly in horses. Not long ago we advised a patient to take Glauber salt, but when the patient asked his apothecary for it, the latter ridiculed the idea, and said that this salt was used for horses only.

Epsom salt cannot be administered to young children, because its action on the delicate mucous membrane of the alimentary canal of the young is too harsh; but Glauber salt can be given with immunity. This fact alone should convince everybody that in most cases sulphate of sodium is preferable to sulphate of magnesia.

Nothnagel, a year or two ago, investigated the action of neutral salts on the intestines. He found that sulphate of sodium—Glauber salt—was the mildest of all; that it first caused a very slight redness, and later induced depletion by emptying the congested capillaries and producing a slightly watery stool. In the inflammatory intestinal disorders of childhood, as for instance in cholera infantum, if administered early in moderate doses, it acts almost as a specific, while sulphate of magnesia induces a severe congestion of the intestinal mucous membrane, and generally destroys the epithelial lining. Experience has proved this observation to be correct, for, generally, whenever especially a larger dose of Epsom salt has been given, the patient will suffer from constipation, or at least from sluggishness of the bowels, for several days afterwards.

The action of Glauber salt is so certain and at the same time so much a true laxative—not causing congestion and not injuring the epithelial lining—that a much smaller dose is generally needed than in the case of the magnesia sulphate. In most cases from one-half to a teaspoonful, if administered to an adult, largely diluted with water—as all neutral salts should be if the intention is purgation—one hour before breakfast, will induce one or two motions of the bowels about half an hour after the meal, and this result will be brought about without the least gripping and without any after-effect, as constipation, so often observed as a consequence of the magnesia salt.

We publish these remarks mainly for the benefit of those who imagine, because Glauber salt is used by veterinary surgeons, that

its use would not be indicated in the case of human beings, for it is used for horses only on account of its cheapness. In every case it should be preferred to Epsom salt, for the reasons given.

#### METALLO-THERAPEUTICS.

Burge first made the interesting observation, that local anaesthesia, especially in those hysterical females who are inclined to trance and similar conditions, may at once yield to the local application of certain metals. That metal which in the individual case caused a momentary disappearance of the anaesthesia, or produced any irritation or change in sensation on local application, is then administered internally, and is apt to cure the anaesthesia permanently, if thus given. The art thus to discover the metal indicated, is called Metalloscopy, while the treatment based upon it is understood by the name of Metallo-therapeutics. Prof. Engel of this city, while reporting an interesting case thus treated, gave a full explanation of this branch of medicine in an article published in the MEDICAL AND SURGICAL REPORTER about two years ago.

Dr. Moricourt (*L' Union Méd.* 14, '86) at the occasion of a meeting of the Academy of Science in Paris, reported the results of his investigations into Metallo-therapeutics. He has come to the following conclusions:

Some neuropathics suffer from local anaesthesia, which does not disappear on external application of metals. In such cases the return of sensibility may be achieved by the subcutaneous injections of certain mineral salts.

Individuals laboring under spontaneous lethargy, catalepsy or somnambulism, also such as may be hypnotized or mesmerized, react in nine cases out of ten on copper or gold, or on both. These metals bring back sensation in these cases.

To discover the metal most indicated in the case, and also the dose best suited and to be employed internally, pieces of metal are placed in rapid succession on the hand or the forearm of the mesmerized person. The one producing most sensation of formication or the like is the one indicated. The dose for internal administration of the same metal must be the less, the more intense the sensation caused by the local application. In one patient a pill containing the sixth of a grain of oxide of copper caused vomiting and diarrhoea. For subcutaneous injections solutions of  $\frac{1}{60}$  or  $\frac{1}{100}$ , dose 5 to 10 minims, are employed. Citrate of iron and nitrate

of silver are the metals most generally used for this purpose.

#### COFFEE AND PRURITUS.

Especially the pruritus ani and pruritus vulvæ are very annoying complaints, which not seldom make those suffering from them feel wretched. The observation has frequently been made that a rich and highly seasoned diet, sometimes even the eating only of certain aliments, decidedly aggravates the intolerable itching. But recently Brown-Squard made a discovery which will surprise many a practicing physician, and serve to explain the often so stubborn character of this troublesome disease. He found that in several instances the drinking of coffee directly produced the pruritus.

Two very nervous patients were especially observed by him for the purpose of investigating this effect of coffee. He convinced himself in both cases that between the appearance of the itching and the drinking of coffee existed a definite relation, so that whenever the patients had taken a larger quantity of coffee than they had been in the habit of drinking, the pruritus at once increased in severity. Still more to prove the relation of cause and effect between the coffee and the pruritus, he forbade the use of coffee totally. The result was as expected by him; the itching in both instances ultimately vanished completely.

If we remember that the vast majority of patients habitually use coffee, at least for breakfast, and provided that this auxiliary aliment produces pruritus, we cannot wonder why the disease proved so rebellious in so many cases. Even should coffee not directly cause the complaint, it surely aggravates it, and it may be well, therefore, totally to interdict its use in cases of pruritus ani or vulvæ.

#### MEDICAL ASPECTS OF SOCIAL QUESTIONS.

If the influence of the medical profession is to be exerted in the manner most effective for the good of humanity, it must be directed to those sociological problems which most nearly concern the perpetuation of the species. Yet, strange to say, this is so little appreciated, that no questions in sanitary and preventive medicine are less discussed than these.

It would not be difficult to put one's finger on the reason for this. Through the influence of dogmatic teaching and false notions of decorum, these questions are laid

under a *taboo*, even in the medical world. Absurd assertions in regard to them continue to pass unchallenged, and though the individual physician may entertain sound and liberal views about them, he fears to express himself, lest his business suffer.

The questions we refer to are such as the propriety of limiting child-bearing, of licensing and registering *maisons de tolérance*, of providing against the spread of contagious specific diseases by periodical inspection, of counteracting the increase of celibacy by judicious provisions with regard to marriage, so as to make it less of a burden than it now is in this country, of facilitating divorce, of providing for the greater independence of of women both in and out of marriage; and there are many other vitally important problems of a similar character.

We had hoped that the increase of enlightened women physicians would have led to broader views on these topics—that some of them would have come forward with knowledge and courage to advocate the needed reforms in these matters, reforms so essential to women securing the influence which they should exert in the social status of the future. But we have looked in vain. No one knows better than women themselves the heavy burden of frequent parturition; but how many women physicians have come forward to denounce it? They, too, should be those to take an active part in the medical control of public women; but no one has so far even advocated such control.

The near future should bring bolder and truer views on these topics, and they should be studied wholly apart from tradition or dogma, and prejudice and fear.

## NOTES AND COMMENTS.

### Inversion of the Uterus.

Dr. M. G. Biggs reports this case in the *Brit. Med. Jour.*:

"It was a middle-aged multipara, whom I had attended once previously, and on that occasion the labor was a simple one. A month or two ago I again attended her; the child was born, and I placed my hand over the uterus, and felt it contracting; but as the placenta did not come, and the patient informed me 'that once before the after-birth had grown to her side, and the doctor had been obliged to remove it,' I asked the nurse to place her hand over the abdomen, intending myself to introduce the hand and remove it. On introducing two fingers, however,

into the vagina, I found a good part of the placenta already there, and so used traction on the cord, which readily brought away, not only the after-birth, but also a large body, which proved to be the inverted uterus; the membranes seemed attached to the surface, and these I pulled off. On placing my hand on the abdomen, no uterus could be felt, and the fingers could be passed well down into the pelvis, owing to the thin abdominal walls; but no trace of a contracted uterus could be felt. My patient now became very pale, her pulse almost ceased, and she said she was going to faint. I gave her a teaspoonful of brandy, and, feeling that no better time than the present could exist for reduction, as the faintness would relax the muscular tissues, I placed both hands against the fundus, and pushed it back into the vagina; then, with three fingers of the right hand, I followed the fundus up the vagina, and had the good fortune to effect complete reduction without any trouble, beyond a certain amount of pressure. There was no bleeding. The contracted uterus could now be felt by abdominal palpation. The faintness passed off, and my patient made an usual recovery.

### Albuminuria Probably Consecutive to Scarlet Fever; Sudden Death.

Dr. Descroizelles, Physician to the Children's Hospital, Paris, recently had under his care the following case, which presents some features of interest. The patient was a boy, aged 12. Three weeks before admission, he was seized with scarlet fever. This, according to the statement of his relatives, followed the usual course. A slight eruption appeared, and was preceded by sore-throat. The eruption quickly passed away. The child was kept in bed, but seemed quite well until seventeen days subsequent to the appearance of the fever; it was then observed that both cheeks were swollen. Three days later, he was admitted into the hospital. His face was oedematous, but there was complete absence of fever. For some days he had passed very little urine, namely, from 120 to 130 grammes in about twenty hours. It contained a very large proportion of albumen. The child was kept in bed, and his limbs were enveloped in cotton-wool. His face and extremities remained slightly oedematous. There was no fever, nor dilatation of the pupils. The lungs and heart appeared normal. The quantity of urine passed was scanty, as before admission, and contained a large proportion of albumen.

On January 22, two days after admission, the child vomited slightly, and said he felt uncomfortable, but could not define his sensations. All of a sudden, he called out, became insensible, and died. The necropsy was made forty hours afterwards. It was observed that the pericardium was healthy, but a thick layer of adipose tissue covered the inter-ventricular groove at the apex of the heart. The right lung presented an area of hepatization; the liver was enlarged, and of a violet color; but there were not any lesions which explained the boy's death.

#### Iodoform in Chronic Catarrhal Metritis.

In atomic external ulceration, iodoform has proved one of the most effective curative agents. Dr. Kugelmann of Berlin employed this drug also in fistulous passages, and when ulceration attacked internal cavities, as the mouth, the nose, the rectum, etc. The great success which he achieved has induced Dr. Weissenberg of Coblenz to test the efficacy of iodoform in chronic catarrhal metritis. The results published by him in the *Berlin Klin. Woch.* 17, 1886, have been very favorable. To get the remedy in a sufficient quantity into the internal cavity of the uterus, Weissenberg had a kind of catheter constructed, bent to suit the curvature of the uterine neck, and through this he pushed the iodoform by the aid of a kind of piston or ramrod into the uterus.

All the cases of chronic endometritis, whether attended by more or less extensive ulcerations or not, at once improved after the very first application, and in most instances but three or four such applications are needed to establish a radical cure. In no case were any bad after-effects noted, the enlargement of the womb rapidly disappeared, and the increase in the catamenial flow ceased. The method surely deserves further trial.

#### Digital Examination of the Nasal Chambers and Denudation of the Turbinated Bones in the Treatment of Chronic Nasal Catarrh.

In the varieties of chronic catarrh in which the discharge is purulent or composed of crusts, the mucous membrane covering the middle turbinated bones will be found to be thickened and softened. In the atrophic form of the disease, the inferior turbinated bone will participate in this condition, and the entire interior of the nose may be lined with membrane which is so far changed from the normal type as to be scarcely recogniz-

able by any of the characters which anatomists employ in its description. Dr. Harrison Allen, in an article on this subject in the April number of the *American Journal of the Medical Sciences*, states that he has for some time been in the habit of studying these altered structures as though they were periosteum and bone respectively, and of being guided in their treatment by principles similar to those which are relied upon in treating the diseases of the periosteum and adjacent tissues. In a word, digital examination of the interior of the nose can be made, the nasal muco-periosteum divided or removed, the bone scraped or excised, with the most encouraging results. Dr. Allen urges that the digital manipulation is an aid to diagnosis of nasal affections, and that the act of denudation is a safe and useful procedure.

#### The Vesiculae Seminales and Skene's Tubes,

Mr. J. Bland Sutton, in an important contribution to the *Journal of Anatomy and Physiology* for April, appears to have proved, from careful dissection of the genito-urinary tract in seventy cows, that Skene's tubes, and the pair of urethral glands with which they are connected, represent the vesiculae seminales and their ducts in the male. The orifices of Skene's tubes may frequently be detected on the margin of the meatus urinarius: and Böhm has described catarrh of the tubes, sometimes of gonorrhœal origin. Max Schüller has definitely traced the communication of Skene's tubes with a pair of glands in the upper part of the urethra. Sutton denies that the tubes are distinct from Gartner's ducts, and has found a glandular diverticulum springing from each, just above its termination in the wall of the vagina in the cow. Precisely the same condition exists, but in a far higher grade of development, in the terminal part of the vas deferens, the homologue of Gartner's duct in the male, and the diverticulum in this case is the vesicula seminalis. In the human female, Skene's tubes and their glands are entirely urethral, and not connected with the vagina, as in the cow.

#### On Strychnine in Dipsomania.

In the *Vratch*, No. 10, 1886, p. 177, Dr. U. M. Popoff, of St. Petersburg, states that, guided by the works of Magnus Huss, Luton, Dujardin-Beaumetz, and others, he employed nitrate of strychnine in two typical cases of dipsomania, and obtained strikingly successful therapeutic results. In one of the patients (a very gifted man of letters, aged 40), the

alkaloid was administered under the skin, in the dose of  $\frac{1}{10}$ th of a grain at first (during a drinking bout) daily, then every other day, then twice a week, etc. The patient ceased to ask for drink after the second injection: within the next two days, various morbid phenomena (headache, weakness, discomfort, etc.) disappeared. On subsequent occasions, a few injections of  $\frac{1}{10}$ th or  $\frac{1}{5}$ th of a grain of strychnine rapidly removed craving, anxiety, irritability, agoraphobia, and other premonitory symptoms of a threatening dipsomaniac attack. The patient each time rapidly improved in all regards, and felt desire for work and society. In another patient, dipsomania disappeared under the internal administration of strychnine, the alkaloid being given for the first two weeks in doses of  $\frac{1}{10}$ th of a grain, and for another two weeks in that of  $\frac{1}{5}$ th, twice a day, in pills.

#### Milk Diet in Chronic Nephritis.

In view of the fact that milk diet had been emphatically recommended by many observers, Dr. Trubatcheff undertook a series of comparative observations on four patients with chronic nephritis (three with the parenchymatous, one with the interstitial form), each of whom received ordinary hospital diet during one period, and either mixed or pure milk diet during a subsequent period of equal duration. The results are as follows:

1. An exclusive milk diet invariably led to a marked increase of the daily and percentage amount of albumen in the urine.
2. The patient's weight fell considerably, without any marked change in his dropsical state.
3. A mixed milk diet also led, in the majority of cases, to an increase in the daily and percentage amount of albumen excreted.
4. Neither pure nor mixed milk diet produced any marked increase in the amount of urine.

The author is now studying the assimilation of protein by nephritic patients receiving milk diet, which study will enable him to settle the question of the treatment.

#### The Influence of Diabetes on Gestation, Parturition, and Menstruation.

According to many authors, diabetes renders women sterile. Six cases studied and treated by Dr. Lecorché contradict this theory. His six diabetic patients were delivered of children at term, but they were all delicate. One child died two days after its birth; another, when 21 months old, be-

came hydrocephalic, with polydipsia. There was no sugar in its urine. A third had a double hydrocele, and was also hydrocephalic, and could not live. Dr. Lecorché concludes that diabetes does not render women sterile. When they do not conceive, it is uterine lesions, resulting from diabetes, that cause their sterility. Diabetes has direct influence on the process of gestation, impairs foetal nutrition, and is favorable to faulty development, especially hydrocephalus. Diabetes often produces dysmenorrhoea and amenorrhoea. Early menopause may result from an overlooked diabetes. The menses may re-appear when the sugar disappears. According to Dr. Lecorché, metrorrhagia in a diabetic patient indicates a co-existent uterine affection, and is not the result of diabetes.

#### White of Egg in Obstinate Diarrhoea.

From the *Allg. Med. Cent. Zeit.*, we learn that Celli has recently called attention to the curative properties of the albumen of hen's eggs in severe diarrhoeal affections. In a discussion before a medical society at Rome, he advocated its use, and related two cases of chronic enteritis and diarrhoea, which, having resisted all treatment, speedily made complete recoveries under the use of egg-albumen. The same diet is strongly recommended in the diarrhoea accompanying febrile cachexia and in that of phthisis. In two cases of diarrhoea dependent upon tertiary syphilis, it was found of no avail. On post-mortem examination, diffuse amyloid degeneration of the arterioles of the villi was found in these cases. The whites of eight or ten eggs are beaten up and made into an emulsion with a pint of water. This is to be taken in divided quantities during the day. More may be given if desired. The insipid taste can be improved with lemon, anise, or sugar. In case of colic, a few drops of tincture of opium may be added.

#### Treatment of Night-sweats.

In the *Gazette Médical de Paris* we find two suggestions as to the relief of phthisical and other night-sweats. They are both simple enough, and certainly merit a trial.

In the first procedure it is directed that the trunk be sponged or rubbed with a mixture of four parts of tincture of belladonna to thirty parts of water. The lotion is best applied by pouring it into the hollow of the hand and bathing the body an hour or two before the expected sweating.

In fifty cases cited, but one failure to suppress the perspiration is recorded.

The second method consists in sponging the body of the patient with a solution of eight grams of chloral hydrate in one goblet each of water and whiskey. If the sponging alone does not suffice, the patient should wear a shirt that has been dipped in the solution and then dried at a moderate heat. In the non-phthisical night-sweat of children this device is said to yield excellent results.

#### Iritis Serosa Occurring Rapidly after Wound of Opposite Eye.

Before the Ophthalmological Society of the United Kingdom, Mr. Edgar Browne narrated the case of a gentleman struck in the left eye by a branch. He traveled to Liverpool from Cumberland; and when first seen the cornea was hazy, the iris was muddy, and in the anterior chamber was a thorn, which had wounded the periphery of the iris. The thorn was extracted next day, but the lens was already opaque on the surface, and the iris was covered with lymph; that night he had violent pain in the right eye, due to iritis. This iritis of the right eye fluctuated, and keratitis punctata appeared in both eyes, though the wound healed well. He eventually recovered, with good vision. Mr. Browne believed that the keratitis punctata was not due to the injury, but had arisen independently, or had, at the most, but a very indirect connection, setting up, perhaps, atrophic disturbance, which determined the onset of an impending keratitis.

#### Cocaine in Hay-fever.

Dr. Seth Bishop, in a lecture recently delivered by him at the Chicago Medical College, alluded to the wonderful effects claimed for cocaine in the treatment of hay-fever. He had made a certain number of personal observations, and summed up his conclusions as follows: First, it was not to be expected that a drug with so ephemeral an influence should be successful in permanently arresting an affection of the nature of hay-fever. Secondly, undoubted relief often followed the application of a spray of the solution, but it required to be renewed every hour or two, if the effect were to be maintained; and such repeated applications were liable to be followed by the absorption and physiological effect of the drug. Thirdly, it produced an anaemic and contracted condition of the mucous membrane, followed, after some time, by congestion and hyperesthesia, the suffering from which more than compensated for any

relief obtained. Finally, this reaction was much more marked in some individuals than in others.

#### Hereditary Tremors.

Before the Medical Society of London, Dr. Samuel West read the history of a cabman who had suffered since his earliest years from constant tremors, not affecting the tongue, eyes, or facial muscles. The most interesting feature of the case was that, on inquiry, his mother and grandmother appeared to have been subject to similar tremors. Further, the patient was one of ten children, and all of them suffered in a varying degree from the same thing, and the condition had been re-produced in his own six children.

Dr. Stephen Mackenzie alluded to a similar case, except that the history had not been so carefully ascertained.

Dr. Angel Money mentioned the frequency with which chronic chorea was transmitted, and the liability on the part of motor disorders to be handed down to the offspring.

#### Hydrophobia in Austria.

Dr. von Frisch, who was lately sent to Paris by a Vienna committee to inquire into Pasteur's system of inoculation against rabies, has given an account of his researches in a public meeting at the Town Hall. He unreservedly commended Pasteur's system, urging that it should at once be adopted by the medical profession in Austria. Giving some statistics on hydrophobia, he said that, in Austria, there had been 135 deaths from this cause in 1874, and 132 in 1875. In 1882, the mortality declined to 77, the lowest figure on record. Dr. von Frisch warmly advocated the compulsory muzzling of dogs in the streets, and thought it a matter for congratulation that the number of dogs should be decreasing. There was now, he said, but one dog in Austria for every section of 116 inhabitants.

#### Obstinate Sciatica Cured by Massage.

Dr. Berne states in the *Journal de Médecine de Paris*, that every therapeutic means failed to improve a case of sciatica of the left lower limb. The patient was 53 years of age, neither gouty nor rheumatic, but had suffered from piles since the age of 18. After the fifteenth massage, the patient could walk. After the fiftieth, he was able to resume his usual avocations, and could take long walks.

## CORRESPONDENCE.

## Why Bright's Disease is so Fatal.

EDS. MED. AND SURG. REPORTER:

The term Bright's disease is used to indicate an organic disease of the kidneys, and was adopted in honor of Dr. Bright, who a half century ago called the attention of the medical profession, in a manner never before so clearly elucidated, to this morbid condition of the kidneys. The word *Albuminuria*, which means albumen in the urine, is also used to designate this same disease of the kidneys; but Bright's disease is the term most generally used to denote this malady of the kidneys.

## THE APPROACH OF THE DISEASE.

In medicine the disease is divided into the acute and chronic; that is, when the disease is sudden and violent it is called *acute*; and when slow and insidious in its approach it is called *chronic*; and whether it comes in the acute or chronic manner, it is always a serious and dangerous disease, sometimes destroying life in a few weeks, or making existence intolerable by its continuance for months or years.

An acute attack sets in with a chill, followed by fever, pain in the loins and back, attended with a marked diminution in the scanty passage of urine, loaded with albumen, which also presents a smoky or dark-brown appearance. Accompanying these symptoms are headache, dry, hot skin, furred tongue, vomiting, and loss of appetite. When an individual suffers from these symptoms, his physician should lose no time in ascertaining the extent of the disease of the kidneys, for upon a correct diagnosis, and careful and proper treatment of the acute stage of the disease, depends the safety of the patient. When early recognized and skillfully treated, two-thirds of all cases of acute Bright's disease get well in a varying interval of weeks or months; but however early detected or skillfully treated, one-third will prove helplessly and hopelessly fatal.

## CHRONIC BRIGHT'S DISEASE.

The chronic form of this disease is more fatal than the acute, for it is both insidious and symptomless in its approach and progress, and the rule is for it to terminate fatally. Two-thirds of the cases of chronic Bright's disease are caused by the habitual use of the compounds of alcohol, and no case thus caused has ever been known to get well while the patient continued to habitually drink alcoholic stimulants. The cause of the uniformity in the fatality of chronic Bright's

disease is entirely attributable to the nature of its silent and insidious approach. Its presence is not suspected by the patient by any symptom that it presents. Whatever symptoms may manifest themselves, are those of ordinary dyspepsia; and it is not until the disease has made an incurable advance that the patient calls the attention of a physician to his condition. Then it is too late. The disease has progressed to such an extent that it has almost destroyed the functions of the kidneys; and all the physician can do is to smooth the way of the patient to a very near death.

It is this symptomless approach of chronic Bright's disease that beguiles the patient and leads him to suppose there is nothing more the matter with him than ordinary dyspepsia, and in obedience to this deception he loses the valuable time necessary for the treatment of the disease.

## THE GREAT PREVALENCE OF BRIGHT'S DISEASE.

The customs of modern society, and the predominance of the habit of dram-drinking, have caused the great prevalence of chronic Bright's disease; and this fact is not only well known to the medical profession, but familiar to the public, and the remarkable insidious character of its approach makes it highly important that a warning should be given to unprofessional persons in relation to it.

That Bright's disease is curable in its early stage is beyond doubt, and that it is absolutely incurable in its last stage is also beyond doubt; therefore, in order to give an individual suffering with this disease all the advantages of medicine, and as there are no ordinary symptoms by which the disease may be detected, the patient should be as early as possible brought under medical treatment. In the absence of an early medical treatment, the chances of a cure are seriously diminished; for when the structure of an organ of the body is once seriously injured by disease, medical art possesses no means whereby it can be restored to its natural vigor. Let it be distinctly understood that in the early stage of Bright's disease there are no symptoms to denote its presence to the unassisted senses; and in order to detect it, chemistry and the microscope are the only reliable resources for an accurate knowledge of the existence of the presence of the disease.

## HOW TO SUSPECT THE DISEASE.

Notwithstanding the constitutional symptoms of chronic Bright's disease are commonly those belonging to any other serious

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disease of the important organs of the body, it *has* certain general bodily signs which, when present, may lead the patient to suspect that there is impairment going on in the kidneys.

There are many diseases which make known their presence by the signs which they present; but it is not so with chronic Bright's disease. Its presence must be suspected and looked for, before it can be designated; and in order to attain this end, it must be searched out from among the multitude of common symptoms that accompany it. This is highly important to the patient; for when the disease is once established, it runs to a fatal termination in six months. As a rule, the tendency of the disease is always towards death; but now and then exceptions do occur, where the patient lives a year or two, and sometimes gets well; but this is far from being the rule.

Chronic Bright's disease is not only a disease of the kidneys, but an evidence of a weak constitution and impaired general health; and when an individual suffers month after month from an impaired appetite, with more or less emaciation, accompanied by a gradual loss of energy and unusual fatigue after bodily exertion, with imperfect perspiration and a tendency to rheumatic pains, a peculiar pale and sallow complexion, with a dry or moist and pallid tongue, attended with a dry and harsh state of the skin, headache, drowsiness, and dimness of vision, accompanied with a watery condition of the eyes, associated with dropsical symptoms about the feet and face, he may reasonably suspect that he is suffering from disease of the kidneys, and should lose no time in having his urine chemically and microscopically examined, and in placing himself under the medical treatment of an intelligent physician.

Pathological anatomy tells us all about the morbid condition of the kidney after Bright's disease has destroyed the life of the patient, but possesses no light to fall upon the *dead* organ and throw back rays to indicate means to relieve the *live* kidney struggling with the disease; and science has not yet presented a treatment that even approximates the removal of that depraved condition of the system that silently starts organic changes in the structure of the kidney; and through darkness and doubt we have to grope, and clutch at such means as seem most likely to help the suffering patient. That albumen does now and then make its appearance in the urine without the presence of serious organic disease of the kidneys is doubt-

less true, but when it occurs continuously, for weeks together in the urine, there can be no question that its continued presence indicates organic disease of the kidneys; and when a physician has a case of Bright's disease under his care, he should tell the patient at once of his condition, and tell him also that no course of medicine will be of any avail whatever, unless assisted on his part by the most perfect temperance and prudence in every act relative to the care of his mental and physical condition.

J. B. JOHNSON, M. D.  
Washington City, D. C.

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*A Card from Dr. Packard.*

In your issue of March 13, the reporter of a clinical lecture of mine at the Pennsylvania Hospital has somewhat mixed up two very different matters, and I beg you will allow me enough of your valuable space to remedy the confusion, which is in the first section, headed "New Method of Applying Extension and Counter-extension."

Your reporter first describes (not very clearly or accurately) the ordinary method in use in fractures of the femur. He next, and as if in contrast with that, gives my plan for making extension in such cases of fracture of the *leg* as may require it. This plan is by no means new, for I published it in *Hays' Journal* for April, 1874, and again in my article on Fractures in vol. iv. of *Ashhurst's Cyclopaedia of Surgery*. Your reporter then recurs to fractures of the femur, but it seems to me scarcely does justice to the demonstration I made before the class. My method of making extension is as follows: I take a strip of adhesive plaster,  $2\frac{1}{2}$  or 3 inches wide, and about 18 inches longer than twice the distance from the sole of the foot to the seat of fracture. Splitting this strip from either end nearly to the mid-point, I place a bit of thin board, as wide as the strip and about 3 inches long, at the middle of the strip on its adhesive side. Now, it will be easily seen that by placing this bit of wood close below the sole of the foot, one split portion of the plaster will correspond to the outer, the other to the inner side of the limb, and each will have two long ends. These ends are now successively heated and applied to the limb, one portion of each passing in front of the ankle, and the other behind it, thence spirally round the calf, over the swell below the knee, then over the swell above it, and so up to the seat of fracture. In this way four strips of adhesive plaster are made to wind spirally round the limb, fitting very

accurately, and giving a very firm and equable hold upon all that portion of it below the seat of injury to the bone.

This mode of applying extending force is, I think, new, but it may be that it has been used by others unknown to me. It was for this only that I made any claim of novelty.

Pray allow me to correct another error, which crept into your report of a lecture of mine, published in your issue of April 3. In the case of railroad injury requiring amputation of the arm, the account reads: "The bone escaped injury, but not so the brachial artery, which was felt distinctly pulsating at the wrist." It should have been: "The bone escaped injury, but not so the brachial artery; this could be felt beating strongly down to a certain point in the wound at the elbow. The pulse at the wrist, however, was not extinct, and it was hoped that the collateral circulation might be sufficient to preserve life in the forearm and hand. As a measure of safety it was deemed necessary to ligate the vessel in the wound."

Trusting I have not presumed too much upon your patience and that of your many readers, I am,

JOHN H. PACKARD, M. D.

1437 Spruce St., May 8, 1886.

## NEWS AND MISCELLANY.

### American Laryngological Association.

The eighth annual Congress of this Association was held in the hall of the College of Physicians in this city, May 27th, 28th, and 29th. The following papers were read:

"Two Instances of Adenoid Disease of the Roof of the Pharynx which exhibited Unusual Features," by Harrison Allen, M. D., of Philadelphia.

"The Intrinsic Muscles of the Larynx," by Prof. Joseph Leidy, M. D., LL. D., of Philadelphia.

"Concerning the Positions of Paralyzed Vocal Bands," by Franklin H. Hooper, M. D., of Boston.

"Laryngeal Vertigo," by Frederick I. Knight, M. D., of Boston.

"Observations on the Use of Some of the Newer Remedies in the Diseases of the Upper Air Passages," by E. L. Shurly, M. D., of Detroit.

"The Simplest and Most Efficient Treatment of Diphtheria," by Wm. H. Daly, M. D., of Pittsburgh.

"The Question of Hemorrhage after Uvulotomy," by E. Carroll Morgan, M. D., of Washington, D. C.

"Further History of the case of Paralysis of the Posterior Crico-Arytenoid Muscles presented at the first meeting of the Association (1879), with report of Autopsy and Exhibition of Specimens," by J. Solis-Cohen, M. D., of Philadelphia.

"A case of Congenital Defect of the Epiglottis, illustrating its Function in Deglutition," by Frank Donaldson, M. D., of Baltimore.

"Buccal Tuberculosis," by D. Bryson Delavan, M. D., of New York.

a "Three cases of Thryotomy; Recovery in each case case with Excellent Voice."

b "Alarming Hemorrhage after Tonsillar Excision Arrested by Torsion of the Artery," by Clinton Wagner, M. D., of New York.

"The Laryngeal Image as seen in Photographs taken during the production of Tones in the Singing Voice, with Lantern Exhibition of Photographs," by Thomas R. French, M. D., of Brooklyn.

"Clinical Notes on Prolapse of the Laryngeal Ventricle, with cases," by George W. Major, M. D., of Montreal.

"A Novel Procedure for the Removal of Sub-glottic Laryngeal Growths," by Wm. C. Jarvis, M. D., of New York.

"Cases of Laryngeal Edema," by T. Amory De Blois, M. D., of Boston.

"A case of Perichondritis of the Larynx, with Specimen," by Charles H. Knight, M. D., of New York.

"A case of Gummatus Disease of the Larynx, with Spontaneous Re-opening of Larynx after Thyroid Laryngotomy," by Edgar Holden, M. D., of Newark.

"Gummatus Infiltration at the Base of the Tongue," by U. G. Hitchcock, M. D., of New York.

"A case of Hysterical Sneezing, Apparently Cured by applications to the Nasal Passages of the continuous Battery Current," by S. Solis-Cohen, M. D., of Philadelphia.

"A Contribution to the Pathology and Treatment of the Respiratory Vaso-Motor Neuroses," by John N. Mackenzie, M. D., of Baltimore.

"Inflammation of the Antrum," by Beverly Robinson, M. D., of New York.

"A case of Naso-Pharyngeal Growth," by Samuel Johnston, M. D., of Baltimore.

"What cases of Nasal Catarrh require Surgical Treatment?" by Clarence C. Rice, M. D., of New York.

The annual dinner was given at the Saint George Hotel.

### OFFICERS FOR THE ENSUING YEAR.

*President*—E. F. Ingalls, M. D., Chicago.

*First Vice-President*—E. C. Morgan, M. D., Washington.

*Second Vice-President*—J. N. Mackenzie, M. D., Baltimore.

*Secretary and Treasurer*—D. Bryson Delavan, M. D., New York.

*Librarian*—Thomas R. French, M. D., Brooklyn.

Drs. Delavan and French were re-elected, but the others are new men. The idea of an excursion was abandoned. The meeting next year will be held in New York.

#### The Preparation of Wheat Flour.

Any reform which aims at improving the quality of bread must be of general and professional interest. Late years have seen considerable changes in this direction. They have witnessed the reduction to something like its true place in public esteem of mere color as a test of nutritive value. People think less of the white loaf than of yore; it is not now the unique model of perfection in bakery that it was once too readily taken to be. There is more respect for its brown wheaten fellow; and while we are not prepared to admit without reserve all the excellencies which have been claimed for the latter, we may fairly allow that it deserves to rank as a food of highly nutritive efficacy. The principle which preserves in the bran, with its nitrogenous, fatty, and saline constituents, some of the best constituents of wheat, is on the whole a sound one. Its one objection is the inseparable association of irritating silicious matter, which often precludes its free use among the sick, and in any case requires that the grain should be ground with more than usual care. This fact also places somewhat of a restraint upon the consumption of such bread even by the healthy. Among various methods which have been devised in order to meet this difficulty, our readers will recall that of Mège-Mouriès, which, by preserving the inner envelope while removing the outer coverings of the grain, succeeded in retaining most of what was nutritious in the bran with comparatively little indigestible or irritant matter. A revival of this mode of preparation has lately been described by Mrs. K. J. Dance in a little paper on bread-making. The authoress claims for her system that it is both more efficient and more expeditious than other processes now in use. Respecting its proper place among such we need not now express an opinion, but the soundness of the theory on which it is based at all events justifies the claim put forward that it should be fairly tested as to its practical value.

#### Association of American Physicians.

Below we give the programme of the first annual meeting of this Association, to be held in Washington, June 17 and 18:

#### THURSDAY, JUNE 17, 10 A. M.

1. Organization. Address by the President, Francis Delafield, M. D., New York.

2. Knee-jerk and Muscle-jerk in Disease, by S. Weir Mitchell, M. D., in conjunction with Morris J. Lewes, M. D., Philadelphia.

3. Typhoid Fever, by F. Peyre Porcher, M. D., Charleston, S. C.

#### Afternoon Session, 3 p. m.

4. Spasm of the Larynx in Rickets, by J. T. Whittaker, M. D., Cincinnati, O.

5. Discussion.—Does the Present State of Knowledge justify a Clinical and Pathological Correlation of Rheumatism, Gout, Diabetes, and Chronic Bright's Disease? Referee, James Tyson, M. D., Philadelphia; Co-referee, W. H. Draper, M. D., New York.

6. Notes on some cases of Diaphragmatic Pleurisy, by E. T. Bruen, M. D., Philadelphia.

#### FRIDAY, JUNE 18, 10 A. M.

7. Certain Elements found in the Blood of Malarial Fever, by W. T. Councilman, M. D., Baltimore.

8. Certain Clinical Facts Connected with Tabes Dorsalis, by H. N. Lyman, M. D., Chicago.

9. Diseases of the Appendix Cæci, by Reginald H. Fitz, M. D., Boston.

#### Afternoon Session, 3 p. m.

10. Peri-Uterine Inflammation, by Wm. M. Polk, M. D., New York.

11. An Experimental Study of Glomerulo Nephritis, by W. H. Welch, M. D., Johns Hopkins University, Baltimore.

12. Bicuspid Condition of the Semilunar Valves, by William Osler, M. D., Philadelphia.

Other papers are promised.

#### Policing the High Seas.

In pursuance of the resolution of the President, who has determined to establish, by means of vessels of the Revenue Marine, a national patrol of the Coast of the United States, so far as it may be practicable under existing law and consistent with the performance of the other duties confided to that service, Captain E. Gabrielson has assumed command of the revenue cutter Hamilton, stationed at this port, and the vessel has proceeded to sea under special orders for the performance of police duty upon her cruis-

ing stations, the limits of which are from Cape Hatteras to Great Egg Harbor Bay. The orders from the Treasury Department require that all in-bound foreign vessels shall be compelled to show clean bills of health before being permitted to proceed up the Delaware Bay and River. In case any sickness is found on board the vessel, or if there have been cases of any contagious disease during the voyage, the craft will be sent to quarantine at the Breakwater. Every effort is to be made to prevent the introduction of cholera into this country, and the Hamilton will continue her patrol during the entire summer.

Quarantine officers will be recognized as follows, viz.: Medical officers or acting assistant surgeons of the Marine Hospital Service in charge of Gulf, South Atlantic, Cape Charles, or Delaware Breakwater quarantines, or any officer of said Service on duty at any port on the interior rivers, the Great Lakes, or Pacific coast, and all quarantine officers acting under proper State or local authority. Special regulations to aid local quarantine authorities will be promulgated hereafter should occasion require.

#### Food Preservatives.

An interesting paper was recently read by Messrs. Sulman and Berry before the Chemical and Physical Society of University College (London); it was important also from its practical bearing on the preservation of foods, and especially milk. Their investigation, limited to the boracic, salicylic, and benzoic compounds, proved that such substances as aseptin, glacialine, and boroglyceride owed their preservative qualities almost exclusively to the free acid contained in them. Boroglyceride contained 25 per cent. of the genuine boracic ether of glycerine, and 75 per cent. of free acid and glycerine in equivalent proportions. The true compound, the ice-like solid, is immediately resolved into free acid and glycerine by the addition of water, and this reaction probably takes place when the true compound comes into contact with aqueous liquid or animal tissue. We agree with the authors of the paper that the use of so much free boracic acid is undesirable and injurious, especially as a preservative of milk for children. Salicylic acid and salicylates are not substances that can be used with impunity, and as they appear to be useless as preservative agents, their rejection is doubly necessary. Again, benzoic acid precipitates the casein of milk. The best agent appears to be ben-

zoate of soda, which is tasteless when pure, is one-third more powerful than boracic acid, and innocuous when taken in small quantities for prolonged periods.

#### The Cholera in Italy.

The news from Italy shows that cholera maintains itself steadily in the city of Venice and at Bari. In the seven days ending May 18th there had been 28 deaths from cholera in Venice, but the number of attacks was set down at only 37, which must necessarily be below the mark. At Bari 79 cases and 32 deaths are reported to have taken place during the same period. In the province of Brindisi the attacks, which never exceeded some five a day, gradually fell to a single one on the 14th inst., and since then no fresh attacks have occurred. There has thus been no increase of cholera in Venice and Bari, and elsewhere the disease has abated. This is, so far, satisfactory. But in view of the early season of the year, it would be very premature to attach too much importance to any apparent diminution in the extent of the epidemic. Last year cholera prevailed off and on for several months in the Spanish provence of Valencia before the sudden outburst early in June, which formed the commencement of a widespread epidemic throughout the peninsula. The failure of the disease to make rapid headway in Italy, whether it is owing to meteorological or other conditions, is, however, favorable to the carrying out of such sanitary measures as are known to hinder the spread of cholera; and in such action the best hopes for Italy now lie.

#### Official List of Changes

OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE  
UNITED STATES MARINE HOSPITAL SERVICE,  
FOR THE THREE WEEKS ENDED  
MAY 22, 1886.

Bailhache, P. H., Surgeon. Detailed as chairman Board for physical examination of candidates for appointment as cadets, Revenue Marine Service, May 19, 1886.

Wyman, Walter, surgeon. Granted leave of absence for thirty days, May 14, 1886.

Stoner, G. W., surgeon. Detailed as recorder, Board for physical examination of candidates for appointment as cadets, Revenue Marine Service, May 19, 1886.

Banks, C. E., passed assistant surgeon. Leave of absence extended four days, May 5, 1886.

Bratton, W. D., assistant surgeon. Detailed as medical officer revenue steamer "Corwin" during cruise, May 22, 1886.

Perry, T. B., assistant surgeon. Appointed an assistant surgeon, May 21, 1886. Assigned to temporary duty at San Francisco, California, May 22, 1886.

#### Medicines for Internal and External Use.

By a notice recently issued in the District of Potsdam in Prussia, it is ordered that the directions to be affixed to medicines for internal use shall be written on white paper, and to those for external use on bright red paper, on which writing with black ink is easily legible. The latter must also be distinctly marked "external." An order regulating the color of the paper to be used has existed since 1825, but its provisions have gradually been transgressed; hence the new regulations. Such regulations as that to which allusion is now made, are scarcely calculated to obviate the danger of mishap. Difference in the color of paper is useful, so far as it goes; but it appeals to the sense of sight alone; and, as we have already urged, it should be substituted or supplemented by an appeal to the sense of touch, by a difference in the configuration of the bottles used respectively for "internal" and "external" medicaments.

#### Cholera at Gibraltar in 1885.

The health officer of Gibraltar, Surgeon-Major F. P. Staples, has addressed to the Sanitary Commissioners of that place an interesting report on the cases of cholera which occurred on the Rock in the course of last autumn. Inasmuch as the cases numbered only 34 in all, and the largest number in any one day was two, their occurrence can hardly be described as an epidemic; but it is nevertheless important that as detailed particulars as possible should be placed on record concerning them. This, Surgeon-Major Staples has been at great pains to accomplish in the report before us. He has nothing specially novel to record as to the exciting causes or behavior of the disease, which seems to have been found, as usual, in association with dirt, overcrowding, and general unsanitary conditions.

#### Lehigh Valley Medical Association.

The sixth annual meeting of this society will be held at the Glen Summit Hotel, Glen Summit, Pa., on Wednesday, June 16.

Glen Summit is a station on the main line of the Lehigh Valley Railroad. The Belvidere Delaware connects with it at Lehigh Junction, just below Phillipsburg. The Central Railroad of New Jersey at Phillips-

burg. The Morris & Essex at Easton. At Bethlehem connection is made with the North Pennsylvania and Lehigh and Lackawanna, and at East Penn Junction with the East Pennsylvania Railroad. For the members and guests in Carbon and Luzerne counties, it is not necessary to give traveling directions. Those beyond Wilkes-Barre can take the Lehigh Valley trains at Wilkes-Barre.

For particulars address the President, S. W. Trimmer, M. D., White Haven, Pa.

#### Epidemic Cholera.

As the warm season advances in the south of Europe, indications of the spread of cholera are again attracting attention. A despatch dated Paris, April 16th, states that sixty-eight cases had occurred in Brindisi, Italy, and that sixteen deaths had taken place between the 8th and the 16th inst. It is reported that very stringent precautions are being taken to prevent its crossing the frontiers of both France and Austria. Still, the officials of Brindisi claim that the disease is sporadic.

#### New York State Medical Association—Fifth District Branch.

The fourth special meeting of the Fifth District Branch will be held in Kingston, on Tuesday, June 15, 1886. All Fellows are cordially invited to contribute to the meeting, either by reading papers, notes or communications, or by exhibiting specimens. The Secretary will be glad to receive the title of any proposed paper as early as convenient.

E. H. SQUIBB, M. D., Sec'y.  
P. O. Box 94, Brooklyn, N. Y.

#### Items.

—The French government has passed a law permitting persons to give their bodies, by will, to learned societies.

—The bill separating the Massachusetts State Board of Health from the State Board of Lunacy and Charity has become a law.

—Prof. Brinton teaches that the only effectual treatment of *anal fissure* is forcible dilatation of the sphincter ani, done thoroughly.

—The curette and a caustic are the best things for lupus, according to Unna. The fashionable caustics are pyrogallic acid and ichthyol.

—Why were the Newark children who were inoculated against hydrophobia, like

Nebuchadnezzar? Ans.—Because they were sent to Pasteur.

—An English physician says he has met with no case of offensive urine (intestinal-vesical fistula excepted) that ten or twenty grains of boric acid, given every three hours, would not cure.

—Dr. Edward Fournié, the distinguished laryngologist and aurist, and for a long time Director of the National Asylum for the Deaf and Dumb of France, and editor of the *Revue Médicale*, died on March 24, aged fifty-three years.

—An Italian Surgical Congress has just been successfully held at Rome. Among the contributions was one by Professor Ceci, recounting the history of a successful splenectomy in which the spleen was one-fifteenth of the body weight.

—It is announced that Dr. A. L. Gihon, U. S. N., has been appointed President of the Section of Collective Investigation of the International Medical Congress, in the place of Dr. H. O. Marcy, of Boston, who has been made Vice-president of the Section of Gynecology.

—The Russian Government has issued an order that the practice of massage is only to be allowed to be conducted by those who have obtained a license after examination in the same way as those who practice medical gymnastics are licensed, and the massage must always be carried on under the orders and supervision of a medical man.

—The Secretary of the State Board of Health of New York reported at the recent meeting of the Board, with regard to the results of vaccination throughout the State toward off the threatened invasion of small-pox from Canada, that the recent experience is a new demonstration that vaccination is a certain preventive of small-pox.

—F. A. Monckton (*Australasian Med. Gaz.*) reports he has cured one case of diabetes mellitus with boric acid. The patient was not stringently dieted, but was given seven grains of the acid three times a day, and at the end of ten weeks the sugar had all disappeared from the urine, the specific gravity being reduced from 1025 to 1016. The drug produces no unpleasant effect.

—Louis Xavier Ollier, the famous French surgeon and medical author, died recently, at the age of sixty-one. He was for many years Professor of Chemical Surgery at the Faculty of Medicine and Pharmacy at Lyons, where he began his famous studies of the bone. He contributed articles to med-

ical periodicals, some of which have been put into book form. Ollier was an officer of the Legion of Honor.

—The Clinical History of King Alfonso, of Spain, has recently been published by his physician, Dr. Tomás Santero, of Moreno. He regarded the anxiety and excitement aroused by the dispute with Germany over the Caroline Islands as the remote cause of the final outbreak of miliary tuberculosis which led to the king's death.

—A man known as "the Sussex giant" died suddenly at Appleboro, Eng., recently. Although only thirty-six years of age, he weighed over 546 pounds. He was on an exhibition tour, and in one of the intervals between the performances he fell asleep in his chair, and when an attempt was made to arouse him he was found to be dead. The cause of death was heart disease.

#### OBITUARY NOTICES.

##### WILLIAM OWEN BALDWIN, M. D.

Advices from Montgomery, Alabama, report the death in that city on May 30 of Dr. W. O. Baldwin. Dr. Baldwin was born in Montgomery, August 9, 1818, his mother being a sister of one of the earlier governors of Alabama. He graduated in medicine from Transylvania University, Lexington, Ky., before he was nineteen years of age, when he settled in practice in his native city. He was a member of many medical societies, a liberal contributor to medical literature, and besides having been President of his State Medical Society, he was, in 1869, President of the American Medical Association.

#### QUERIES AND REPLIES.

##### A PER CENT. SOLUTION.

Will you please state, under "Queries and Replies," what the component parts of a—say 4-per cent. solution are? My idea is, 96 grains of water and 4 of the drug used. We have had some difference of opinion here as to how various per cent. solutions are made, and would therefore be glad to have your solution to the problem.

S. N. M.

*Ans.*—Your idea is correct.

EDS. MED. AND SURG. REPORTER.

##### PRURITUS AND SWEATING HANDS.

In your journal of the 3d inst. is a query for the cure of pruritus. I am troubled occasionally, perhaps two or three times a year, when about to retire for the night, with an intense itching about four inches below Poupart's ligament, which always disappears after one, two, or three applications of tinct. nitrosi, and citron ointment, and immediately before lying down, rubbing with the forefinger a minute or so.

Now, I would like to know a remedy for sweating hands. I have a patient (female) near twelve years old, from whose hands the perspiration will run like water off her fingers when she attempts to sew or use her hands for anything especially. It has always been so.

EDW. VANDERPOEL, M. D.

228 East 68th St., New York City.

N. B.—Boracic acid has no effect.